MEDICARE PHYSICIAN PAYMENT REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

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MEDICARE PHYSICIAN PAYMENT REFORM

THURSDAY, MAY 25, 1989

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:49 a.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. We want to welcome everyone to our subcommittee hearing this morning. We are meeting to hear testimony on potential reform of the way Medicare pays for physicians' services.

The Committee on Energy and Commerce has been vitally interested in this subject for several years. Our interest grows out of an awareness of the many deficiencies in the current payment methodology and our increasing dissatisfaction with the ad hoc budget reductions we have had to make to comply with budget reconciliation instructions.

Previous initiatives of the committee have included establishing the Prospective Payment Review Commission, requiring the Secretary to commission a study of resource-based relative values, fee reforms for radiology, anesthesiology, and pathology, and differential increases and decreases in payments for selective physicians' services, including bonuses for primary care services and for physicians' services furnished in rural, underserved areas.

The health services research community, physician organizations, patient groups, and many others have also been deeply interested in payment reform and have devoted extensive resources to developing and analyzing potential reforms. Much progress has been made. Of particular note is the third annual report of the Physician Payment Review Commission published last month which lays out a comprehensive strategy for reform.

I believe the subcommittee now has the opportunity to report legislation making fundamental changes in Medicare payments for physicians' services. If we can agree on a strategy that has broad support among patients and physicians, we should be prepared to enact a plan now that could be fully implemented over several years. Implementation on a gradual, phased in basis could provide some predictability and stability in an area that has been quite volatile and could permit us to devote more of our attention and energy to other important issues in assuring access to quality care.

Before recognizing our witnesses today—we have a very distinguished group of witnesses—I want to see if members of the sub-

committee will want to at this point give an opening statement, and let me call on Congressman Fields.

Mr. FIELDS. Mr. Chairman, thank you very much.

Let me just say, I am very concerned about this issue and the implications for the State of Texas, both for consumers in Texas but also for physicians.

Also, I would ask consent of this committee to insert in the record a statement from Congressman Tom Tauke. He wanted to express his regrets, but he had pressing business in Iowa this morning, and he asked me to submit this statement for the record and said that he looks forward to working with you on physician reimbursement reform.

Mr. WAXMAN. Thank you very much.

Let's ask unanimous consent that all members may be permitted to insert an opening statement in the record, so we will cover Mr. Tauke and other members who are not here this morning. Without objection, that will be the order.

Mr. Wyden.

Mr. WYDEN. Thank you very much, Mr. Chairman.

I think the subcommittee has turned now to an issue of enormous importance, and I commend you for leading us into this inquiry. Clearly, we are looking at one of the fastest growing parts of the medical equation in this country, the question of physician payments, and it seems to me that there is no logical reason for continuing what we do today, which is, in effect, to make payments based on historical practices.

But, at the same time, I am very concerned that before we embark on a new system, that we address some very serious questions that at this point are unanswered. In particular, as we look at the notion of a relative value system, I am concerned about what it is going to mean to access to medical care in this country. At this point, I have not seen any adequate analyses of what the relative value system would mean with respect to access to care.

Millions of Americans have joined the ranks of the uninsured in the 1980's, and I think that every Member of Congress wants to make darned sure that millions more don't join the ranks of the uninsured in the nineties as we look at these new reimbursement systems. I, for one, am not going to back any physician payment reform approach that does reduce access. That will be one issue I will be particularly interested in looking at as these hearings go forward.

Mr. Chairman, I thank you for the opportunity to join you and look forward to our witnesses.

Mr. WAXMAN. Thank you very much, Mr. Wyden.

Mr. Dannemeyer.

Mr. DANNEMEYER. Thank you, Mr. Chairman.

Thank you for holding these hearings, and I will look forward with interest to some rationale as to why many of the geographical areas of my State of California are currently being reimbursed for physician payments at significant levels below the cost of doing business in those communities. I am not sure I understand why, but I look forward to maybe an analysis of how we can correct this disparity.

With respect to the comments that my colleague, Mr. Wyden of Oregon, addressed with respect to the growing number of uninsured people in America for health insurance. I share that concern very deeply, and I hope we can find a solution to that as well. I suspect one of the reasons may very well be that the State mandates adopted for good reasons by State legislatures to broaden coverage for subscribers of health insurance in those States have resulted in, for all practical purposes, placing the cost of the insurance beyond the means of certain people who only want basic coverage, not with so-called frills. That is not exactly on the hearing this morning, but I think it deserves our attention at some time, Mr. Chairman.

Thank you very much.

Mr. WAXMAN. Thank you, Mr. Dannemeyer.

Mr. Walgren.

Mr. WALGREN. Thank you, Mr. Chairman.

I, too, want to say how important I feel these hearings are and admire the way you, as chairman of this subcommittee, have been able to cover the wide range of health issues that are under the jurisdiction of this subcommittee, and being able to have these hearings today is further testimony that this subcommittee is covering the ground, and covering the ground well, that it must.

The question of access is obviously one both of high costs that may not be necessary, taking up available resources that otherwise could be allocated to providing access in the system.

I noticed the chairman was on national television this morning discussing a case of an individual, a young child that is being denied access to transplant surgery because there is no money. At the same time, access is intimately involved in having people there, ready to provide the services, and that, of course, requires proper support for them across the board.

So it is a very intractable dilemma, in a sense, and I hope that the testimony we might be able to take would shed some light on the direction we ought to go.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Walgren.

To start off our hearing, we want to welcome two of our colleagues, the Honorable Jim Slattery from the State of Kansas, and the Honorable Wayne Owens from the State of Utah.

As we look at these reforms in physician reimbursement, we have to be concerned about access, quality, price, how it affects the urban areas as well as the rural areas, and two of our colleagues want to bring some of these issues to our attention.

Mr. Slattery, we are pleased to have you with us. You are a member of the full committee and have been interested in many of these health issues in the past, and I understand you have legislation we will want to look at as well.

For both of you and for all of our witnesses today, your prepared statements will be in the record in full. We would like to ask you to limit your oral presentations to no more than 5 minutes.

[The prepared statements of Hon. Thomas J. Tauke and Hon. Michael Bilirakis follow:]

Statement of the Honorable Thomas J. Tauke
Subcommittee on Health and the Environment
Hearing on Physician Payment Reform
May 25, 1989

Mr. Chairman, I commend you for convening today's hearing to discuss physician payment reform. The current reimbursement system, with its undervaluation of primary care services and its inequitable geographic differentials in payments for the same services, is contributing directly to the serious shortage of physicians in rural America and thus undermining access to health care for 25 percent of our nation's population.

If you represent Iowa or another rural state, finding a letter like this on your desk is an all-too-common an experience.

> "As of October 1, 1988, I am quitting rural and primary care for urban emergency medicine. I am told that nearly 400 primary care positions are wanting in Iowa today. In Burlington, six of seven board certified family physicians and two of three general internists have quit in the past three years. In Clarinda, two G.P.s may quit this year with no replacement.
>
> "An entire generation of well trained family physicians educated at federal expense will

> sacrifice their skills and dreams to the harsh realities of a reimbursement and liability climate which doesn't permit their skills to bear fruit. Who will care for rural, elderly Iowa now? Not I sadly. I leave $30,000 poorer for three hard years effort. I'm lucky, as...one internist and one family physician left bankrupt. But I will sorely miss family practice."

In Iowa and across much of rural America, we are losing our family physicians, the primary source of basic health care services for rural Americans. At this time, 178 Iowa communities are offering 330 full-time family physician positions. We are suffering a net loss on average of 10 physicians a year, and losses have been as great as 30 per year. The family practice physicians we are losing, moreover, are in their 30's and 40's, their prime practice years. These losses are more compelling in light of the fact that Iowa has one of the strongest community family practice residency programs in the nation. We have eight decentralized family practice training sites, graduate 55 to 60 physicians a year, and retain 60 percent in Iowa, at least initially.

What we are seeing is the long-term effect of historic inequities in the Medicare physician reimbursement system: the undervaluation of primary care services, substantial geographic differentials in payments, and substantial urban/rural

differentials in payments within states and regions. These inequities discourage medical students from choosing family practice, make it difficult and often impossible for rural communities to recruit physicians, and make it difficult to sustain rural practices.

Congress is poised to undertake comprehensive physician payment reform. If we fail to address these inequities as part of that reform, use that reform to provide incentives for rural practice, and move beyond reimbursement to consider other barriers to attracting and retaining physicians in rural practice, we will be condemning a quarter of this nation's population to a deteriorating health care delivery system.

All too often, Congress shapes policies that may work well in an urban setting but which work against rural health care delivery. To effectively restructure Medicare physician reimbursement policy to stem the exodus of physicians from rural America, we must work from a basic understanding of the demands and unique characteristics of rural practice.

1. Medicare dependence

In rural Iowa and many other rural areas, 50 to 70 percent of a physician's patients are Medicare beneficiaries. Thus, the rural physician's practice is disproportionately affected by Medicare reimbursement rates, freezes, and cuts and is

particularly sensitive to changes in reimbursement policies.

2. Scope of practice

The rural physician must be prepared to diagnose and treat a wider variety of conditions and types of patients than urban physicians. Urban physicians have greater control over their patient mix. They can focus on "low overhead" patients, such as adults, and do little if any pediatric care, which is generally under-reimbursed. Rural physicians, with few if any colleagues in their communities, are very limited in their ability to control their case-mix and services. Independent laboratories and diagnostic treatment facilities are less likely to be available in rural areas, requiring the rural physician to have these capabilities "in house."

3. Overhead costs

Office space is generally less expensive in rural areas, and clerical staff costs may be less. But rural physicians must offer salaries competitive with urban areas to attract nurses and allied health professionals to their practice. With the growing shortages of nurses and allied health professionals, many rural practices may in fact be paying more.

Practice management costs may be higher for many rural physicians than urban physicians. Rural physicians are much less

likely to have computerized billing systems or have access to practice management services.

It is also important to note that while leasing costs may be lower in rural areas, many rural physicians maintain more than one practice site.

Rural physicians generally do not have access to the economies of scale in purchasing that urban physicians do, and due to rural physicians' scope of practice, the standby time for expensive diagnostic equipment may become a significant overhead factor.

The rural physician may also have higher malpractice costs, as a component of overhead, than urban costs, since the costs may be spread over fewer cases.

While correcting the under-valuation of primary care services and the inequitable and largely indefensible geographic differentials and rural/urban differentials are centrally important to ensuring access to basic health care services in rural areas, we need to go further.

First, because of population sparsity, geographic isolation, and the percent of indigent and uninsured, some rural and urban areas will never be attractive practice sites. If we are committed to ensuring that all of our people have access to basic

health care services, we must consider providing more reimbursement for services provided in these areas than for services provided in areas where access to primary care services is not a problem. We made a step in this direction in the 1987 Omnibus Budget Reconciliation Act, which provides a five percent bonus for Medicare services in health manpower shortage areas. We need to refine our tools for measuring access problems and increase the bonus for services in these areas.

Second, we need to increase funding for the loan repayment program created in the reauthorization of the National Health Service Corps.

Third, we must expand the Area Health Education Center program and the Rural Health Medical Education Demonstration Projects and similar initiatives. In addition to increasing the availability of primary care services in the rural training sites, these programs also provide opportunities for rural physicians to interact with their colleagues at urban teaching institutions. Furthermore, we have studies showing that doctors tend to practice within 60 to 90 miles of the site of their last residency. Exposure to rural practice through these programs may thus increase the number of physicians who choose to practice in rural areas.

Fourth, we need to examine federal and state support for medical education and provide incentives for expanding family

practice programs. We might wish to consider, for example, weighting direct medical education payments to provide more support for family practice residencies and less for subspecialties. We should also consider incentives to encourage schools of medicine to examine their admissions practices and more actively recruit students from rural areas.

Fifth, we must address the serious problems rural hospitals are having under the Prospective Payment System. Communities without access to hospitals are simply not able to attract and retain physicians. In rural areas, hospitals serve as the locus not only of inpatient and outpatient care, but often of home health care and long-term care. They are at the heart of the rural health care delivery system.

Sixth, rural physicians are more likely to come under PRO review due to the three percent random sampling of hospital records requirement. A particular physician's record is more likely to appear in that sample when he or she may be one of only several physicians admitting to a hospital. Rural physicians frequently cite PRO review as one reason for leaving rural practice for urban areas. We need to find a fairer way to structure random sampling.

option for physicians. I think we have agreed as a nation that individuals should not be denied access to quality care because of inability to pay or because of where they happen to live. Fundamental reforms of Medicare policies to reflect the unique characteristics and demands of rural practice will move us far along the road to our ideal of universal access to basic health care service.

STATEMENT OF MICHAEL BILIRAKIS

MR. CHAIRMAN, I commend you for holding this hearing today because I believe the medicare reimbursement system for physicians causes a great deal of frustration throughout our country for most doctors. I agree with you that changes are needed within the current Medicare fee schedule system for physicians.

I cannot tell you the number of times I have heard from doctors in Florida who want to register their complaints about the Medicare reimbursement program. And while the intentions of this hearing today are good, I believe that we need to evaluate the serious repercussions the relative value scale system may create for certain doctors.

I am particularly concerned about the effects this proposal will have on physicians from the state of Florida. As you can well imagine, there are many specialized doctors in my state and I am already receiving letters from them expressing their opposition to this new fee schedule. One nuclear medicine physician who wrote to me said that the new RVS fee schedule will result in a 40% reduction in Medicare payments for nuclear medicine procedures. He believes that this decrease will make it difficult to maintain the quality of care which has been available to all patients in the past.

In addition, I have been reviewing tables prepared by the Health Care Financing Administration which illustrate the impact that the proposed RVS schedule has on physicians who specialize in certain fields of medicine. In addition, it also details how the geographic location of a doctor will affect his Medicare reimbursement.

Mr. Chairman, I do not know if you have had the opportunity to review these charts, and while I understand that these are preliminary figures, I am deeply disturbed by the fact that Florida doctors, on the average, do very poorly compared to the rest of the country. Mr. Chairman, I would like to take the opportunity to work with you on this inequity and discuss with you a possible solution for my state.

Again, thank you for allowing me this opportunity to share my concerns with you on this matter and I look forward to working with you on this issue in the weeks to come.

STATEMENTS OF HON. JIM SLATTERY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS; AND HON. WAYNE OWENS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Mr. SLATTERY. Mr. Chairman, thank you very much.

It is a pleasure to appear before this subcommittee, and I appreciate the time that the members of this subcommittee are devoting to this issue, which is extremely important to, I think, the country in terms of trying to reform this Medicare reimbursement system for physicians in an effort to try and save some money and make the whole system more equitable. It has particular repercussions for rural America, and I wanted to just focus for a few minutes on that dimension of it.

The current Medicare reimbursement system has a negative effect on the ability of rural communities to attract and retain physician services. Presently, doctors can earn more money in big cities than they can in many rural communities. For example, the Congressional Research Service has reported that the reasonable charges of some Medicare services vary by as much as 200 percent between geographic areas.

When we look at problems facing rural physicians today, we must do so in the context of looking at rural communities as a whole. The bottom line is, without doctors in these areas there can be no hospitals and no access to primary care. This is ironic in light of the fact that there is a heavy dependence on Medicare in these areas. In rural Kansas and other rural areas around the country, 50 to 70 percent of a physician's patients are Medicare beneficiaries. Accordingly, they are disproportionately affected by Medicare reimbursement rates, freezes, and cuts.

Other factors which are important to consider are the rural physician's scope of practice and overhead cost. The rural physician must be prepared to diagnose and treat a wider variety of conditions and types of patients than urban physicians. Urban physicians oftentimes have greater control over their patient mix. Rural physicians, with few, if any, colleagues in their communities, are very limited in their ability to control their case mix and services.

Office space generally is less expensive in rural areas, and clerical staff costs may be less, but rural physicians must offer competitive salaries with urban areas to attract nurses and allied health professionals to their practices. With the growing shortages of nurses and a..ed health professionals, many rural practices may, in fact, be paying more, and I would observe that this is something that has changed in the last few years.

It is also important to note that, while leasing costs may be lower in rural areas, many rural physicians maintain more than one practice site. The rural physician also may have higher malpractice costs, another significant change in the last few years, as a component of overhead than an urban colleague, since extra premiums charged to cover certain procedures may be spread over fewer cases.

As the chairman will recall, during the 1987 budget reconciliation debate, the committee supported an amendment which I offered to begin to reduce the disparity in physician reimbursement

under Medicare. Specifically, my amendment established a floor for primary care services under which physicians who were being reimbursed significantly below the national average received higher updates than those significantly above the national average.

The recognition by the committee of the historical disparity in Medicare reimbursement underscores our need to initiate a complete overhaul of the current system. I would like to highlight just a few examples of the existing disparities in the program which I believe should continue to motivate this subcommittee to further its effort in this initiative.

Today, in all but two counties in Kansas, physicians are paid $49.68 for a limited consultation. This is the payment rate for physicians in Kansas, irrespective of specialty. At the same time, however, in Johnson County, KS, which is in a different Medicare locality, physicians receive either $58.68 for this service if they practice general medicine or $70.53 if they specialize. In Los Angeles, CA, this service is reimbursed at a rate of $45.58 for general practitioners and $74 for specialists. In New York City, this service is reimbursed at the rate of $49.88 for general practitioners, which is about the same, but specialists get $117.59.

These numbers tell us several things. First, while I have mentioned the impact of the current reimbursement system in rural areas, it is important to note that the existing disparity in Medicare reimbursement is not solely an issue of rural States versus urban States. The disparity exists in individual localities and between physicians within the localities. Our historical application of the Medicare economic index has exacerbated the differentials evident in the early 1970's to a point where Medicare prevailing rates have increased exponentially in some localities and for some physicians while other localities and other physicians have been left behind.

To illustrate this statement, let's assume that back in 1973 general practitioners in a locality received $20 for an office visit and specialists received $45 for the same service. Over the past 16 years, let's assume that the MEI increased cumulatively by 64 percent, or about 4 percent per year. In 1989, general practitioners would now receive only $32.80 and specialists would receive $73.80. Although this example is hypothetical, I believe it serves as a real barometer for measuring the differences in Medicare payments for physicians' services, and the differences shown in this example can be applied nationally as well as locally.

Today, the subcommittee will explore many options to reform the Medicare reimbursement payment system. Those available to us include the resource-based relative value scale, which has received much attention, and initiatives to place expenditure targets on physicians' services, and H.R. 1271, which I introduced. I would like to briefly offer the subcommittee my perspective on each of these initiatives.

With respect to the relative value scale, I support the basic premise of this initiative to pinpoint a common dollar value for the provision of individual services by physicians. Considerable discussion should take place as to whether this common dollar value should be modified by outside factors commonly referred to as geographic multipliers.

I would caution the committee that in reviewing the applicability of geographic multipliers we must not forget that the basic premise of an RBRVS is to establish equity in Medicare reimbursement among all physicians—regardless of where a physician practices and without regard to physician specialty. As such, we must be certain that geographic multipliers do not distort our intention to inject equity into the Medicare physician reimbursement system.

I would further point out that the subcommittee is in receipt of several studies on RBRVS—the Physician Payment Review Commission and HCFA—which point to different effects of applying geographic multipliers to a relative value scale. Quite frankly, I am concerned that the multitude of information on this subject has yet to receive the consideration necessary to make a reasoned decision on our intended reform.

With respect to expenditure targets, as I understand it, limits would be placed prospectively on the total dollar amount which a physician received in a preceding year. I am concerned that this approach, while attractive in containing costs, is inflexible with respect to actual physician practice patterns, and relies much too heavily on the existing system which we know to be wrought with disparities. Additionally, this approach ignores our principal goal of establishing equity in the Medicare reimbursement system.

One additional minute, Mr. Chairman. I will move quickly to H.R. 1271, a bill which I have introduced, which would provide an interim national fee schedule by establishing first local and then national median prevailing charge levels for the top 100 volume services under Medicare part B.

My proposal would eliminate specialty differentials within localities, define the upper and lower bounds of Medicare reimbursement for these 100 procedures, which represent approximately 70 percent of physicians' spending under Medicare part B, and allocate inflation updates for local prevailing rates below the national average. I developed this proposal basically out of concern that the questions surrounding RBRVS would be unanswered when the committee considered fiscal year 1990 reconciliation legislation.

It is my intention that H.R. 1271 be considered by the subcommittee, that it be reviewed as an interim solution until the RBRVS initiative is ready to be implemented, and, as I think our colleague, Mr. Wyden, just indicated, there are serious concerns about it, and I would just observe that the proposal that I have offered is something that is moving in that direction, it is consistent with the objective of RBRVS, and it should be viewed as an interim measure that will hopefully establish some equity in the system and hopefully save some money as we move forward.

So I thank the chairman and the members of the subcommittee for giving us the opportunity to appear here today.

Mr. WAXMAN. Thank you very much, Mr. Slattery.

Mr. Owens.

STATEMENT OF HON. WAYNE OWENS

Mr. OWENS. Mr. Chairman, members of the subcommittee, I am very pleased to have the chance to appear very briefly before you this morning. I am very cognizant of the fact that each of you is

undoubtedly more an expert than I on these complicated issues. But I bring, I think an interesting background and some interesting facts before you.

There is a glaring inequity in the physician reimbursement formula, and I am very pleased that the subcommittee is having a look at it. These vast regional differences which exist are excessive, unaccounted for on the basis of practice costs and, thus, are genuinely indefensible. The current system is completely out of whack, and doctors and the elderly in various regions around the country, including my own State of Utah, are being discriminated against.

We must institute a uniform national reimbursement schedule with geographic distinctions based only on real and demonstrable differences in the cost of practice. The PPRC indicated to Congress that finding a way to make geographic adjustments to the resource-based relative value fee scale must be an important component of the reform proposal, and I strongly agree.

The issue is of particular concern to me, Mr. Chairman, obviously, because patients and physicians in my State of Utah are experiencing marked fee reductions, suffering more than most States from the regional differences in Medicare payments for similar services.

The 1988 PPRC study showed that all of the prevailing Medicare charges in Utah are substantially lower than in most areas of the country, and in some instances Utah is dead last. For example, the Utah payment for a pacemaker insertion is $680 while the national average is $1,228, almost double. There is no rational explanation for these dramatic differences.

Forgive me, Mr. Chairman, but in Beverly Hills sometimes physicians get paid three to four times as much as they do in Utah for exactly the same procedure, and that is not to take on your district, Mr. Chairman, as against mine. That would be, obviously, very unwise. If we get you in front of the Interior Committee, that might change, but in front of your subcommittee, Mr. Chairman, I wouldn't want to do that.

Mr. WAXMAN. You would probably make Beverly Hills a national park.

Mr. OWENS. There are some who would like to make a wilderness out of it, but I don't think our neighboring State of Nevada, for example, has almost double the payment for many major procedures. Office space may be less expensive in some rural areas, but in order to attract qualified support staff to rural areas, competitive wages may, in fact, be higher. Many times, costs balance out, but Utah Medical Association data indicate that the actual costs of practice, including malpractice insurance, employee expenses, office rent, and supplies, are not substantially lower in Utah. In some cases, Utah costs are higher, yet we are reimbursed at much lower rates.

The thrust of my testimony, Mr. Chairman, is not to increase payments to doctors living in my district, though that is what I have told them. It is, rather, genuinely, to try to improve the quality of service to all Americans by equalizing access to basic health care services—equal access through readjusting the formula for patient fees.

Medicare is, after all, a national health insurance program for the elderly, and every citizen in the United States pays equally into Medicare. Regardless of where they live, all Americans are subject to the same Federal tax and Social Security payment schedule. All Medicare enrollees also pay the same premiums for physician coverage, yet physicians who live in certain parts of the country receive a disproportionate reimbursement for the same services. Thus, taxpayers in some parts of the country are subsidizing more expensive medical care for citizens in other areas. The paradox is that less prosperous areas are subsidizing more prosperous areas, and that is counter to what we ordinarily think that we do in this country with our Federal Government.

I read with interest in the paper earlier this week the report that the Department of Health and Human Services submitted to Congress recently on the new proposed payment system. The new system will help areas such as Utah which have been underreimbursed in the past, but we must continue to ensure that geographic modifiers are adequately addressed and reimbursement rates are based on legitimate costs of medical practice.

Recently, I, too, introduced some legislation. This would express my conviction that any new mechanisms for Medicare physician reimbursements that are developed should not permit geographic variations beyond those which can be justified by legitimate differences in the cost of medical practice.

So, in sum, I express my appreciation to your subcommittee. I am delighted you are looking at this problem. It is very real. It impacts on quality and delivery of services, and I am grateful that this distinguished subcommittee is having a look at that.

[The prepared statement of Mr. Owens follows:]

PREPARED STATEMENT OF WAYNE OWENS

Mr. Chairman, I would like to thank you for the opportunity to testify before the subcommittee and for your continued commitment to sound health policies. As Congress is poised to undertake comprehensive Medicare physician payment reform, we must not fail to address a glaring inequity in the physician reimbursement formula. This inequity stems from the geographic disparity in physician reimbursement.

Presently, there are regional differences in fees paid to physicians for identical services. These differences are excessive, unaccounted for on the basis of practice costs, and thus, indefensible. The time has come to remedy the current geographic differentials in payments, especially the substantial urban/rural differentials within States. Our current system is completely out of whack, and doctors and the elderly in various regions around the country, including my State of Utah, are being discriminated against. Most critical, unrealistic Medicare payments are jeopardizing access to quality care. We must institute a uniform national reimbursement schedule with geographic distinctions based only on real and demonstrable differences in the cost of practice.

The Physician Payment Review Commission [PPRC] has indicated to Congress that finding a way to make geographic adjustments to the resource-based relative value fee scale must be an important component of the reform proposal. I have introduced legislation to assure that those critical geographic components and regional fee differences are sincerely addressed and this legislation is supported by the American Medical Association.

This issue is of particular concern to me because patients and physicians in my State of Utah experience marked fee reductions, suffering more than most States from the regional differences in Medicare payments for similar services. The 1988 PPRC study showed that all of the prevailing Medicare charges in Utah are substantially lower than in most areas of the country. For some services, Utah is dead last. Utah's Medicare allowable fees are extremely low for both surgical procedures and office visits. For example, the Utah payment for a pacemaker insertion is $680

while the national average is $1,228—almost double. Utah ranks 12th from the bottom out of 117 Medicare geographic localities that were surveyed. There is no rational explanation for these variations in reimbursement from State to State. Costs do not explain it.

The PPRC also reported that "prevailing charges vary extensively from one locality to another. Three and fourfold differences in charges for particular procedures are common". It is impossible to justify the fact that physicians in one part of the country can receive up to four times the Medicare reimbursement that physicians elsewhere receive for identical medical procedures. These discrepancies extend far beyond differences in the cost of practice or the cost of living. Physicians in Utah's neighboring States receive up to 20 percent more for certain services. Nevada receives nearly double the amount Utah receives for some procedures. Practice costs and cost of living variables do not justify the differences. A doctor in rural Utah should not be expected to subsidize someone who has chosen to practice in Beverly Hills. Office space may be less expensive in rural areas but in order to attract qualified support staff to rural areas, competitive wages may be higher. Many times costs balance out. The Utah Medical Association's data indicates that the actual costs of practice, including malpractice insurance, employee expenses, office rent, and supplies are not substantially lower in Utah. In some cases, Utah's costs are higher yet we are reimbursed at much lower rates.

The thrust of my testimony, Mr. Chairman, is not to increase payments to doctors living in my district. It is rather, to improve the quality of care to all Americans by equalizing access to basic health care services through readjusting the formula for paying fees.

The greatest impact of these unrealistic Medicare payments is felt by our elderly and disabled citizens because severe underpayment to physicians can directly affect not only the quality of care, but the availability of certain services, an issue which the PPRC also addressed. They concluded that "wide variation in charges unrelated to differences in the cost of practice could mean access to care and beneficiary financial protection might be compromised in areas where prevailing charges are low". Prevailing charges in my State of Utah are unexplainably low and access to quality health care is being jeopardized in Utah because of the inequalities in the national system. Reforms must be instituted to protect Medicare beneficiaries and assure continued access to affordable care. Payments to physicians are a means for achieving that objective.

Furthermore, Medicare is a national health insurance program for the elderly and every citizen in the United States contributes equally to Medicare. Regardless of where they live, all Americans are subject to the same Federal tax and social security payment schedules; all Medicare enrollees pay the same premiums for physician coverage. Yet physicians who live in certain parts of the country receive a disproportionate reimbursement for the same services. Thus, taxpayers in some parts of the country are subsidizing more expensive medical care for citizens in other areas. The paradox is that less prosperous areas are subsidizing more prosperous areas. Medicare beneficiaries who pay the same premium should receive the same level of care.

Recently, I introduced legislation to express my conviction that any new mechanisms for Medicare physician reimbursements that are developed should not permit geographic variations beyond those which can be justified by legitimate differences in the cost of medical practice, or the need to maintain access to high quality health care. Fairness demands a uniform fee schedule based on real costs of delivering health care—not on the cost of living and other irrational geographic differentials. After examining the factors that could explain these geographic differences in charges and reimbursements, the PPRC concluded that "practice cost differences accounted for some variation but not all". Even the PPRC acknowledges there are no consistent factors that justify variation in charges and reimbursements. We simply cannot endure these disparities.

Mr. Chairman, I want to thank you for your efforts to curb soaring health care costs, and develop a Medicare system that is rational, current and fair. The proposed national fee schedule has been proclaimed a "level playing field" and once that is in place I want to go one step further and protect fair play. As Congress undergoes a radical overhaul of the way Medicare pays physicians I urge my colleagues to join with the Utah delegation in calling for an end to a system that threatens access to quality health care by allowing inequitable geographic disparities to exist. Measures must be included in the new physician payment formulas to guarantee uniform, unbiased treatment of physicians and their patients, practicing and living in discriminated areas such as Utah.

Any system that permits unjustified regional differences is unfair to the American taxpayer and Medicare participant living in certain areas of the country. In a Nation that views health care not as a privilege, but as an unalienable right—along with life, liberty, and the pursuit of happiness—we must ensure that good medical care is available for our elderly and disabled citizens—no matter where they happen to live.

Mr. WAXMAN. Thank you very much, Mr. Owens.

What I hear from both of you is that it doesn't seem to make sense to have a differential in the payment for the same service between a specialist and a generalist, so to speak, in the medical profession or to have a huge disparity based on geographical difference when there is no real difference in terms of the cost of practicing medicine from one area to another. These are clearly issues we have got to look at very carefully. I know the Payment Review Commission has evaluated it. We are going to hear from them very shortly. As we look at reforms, these are two areas where I think we need to make clear reforms, and I thank both of you for bringing this to our attention.

Mr. SLATTERY. Mr. Chairman, I would just offer two examples that sort of highlight some of the points we are talking about. I haven't checked in the last year, but I think about 18 months ago a surgeon, for example, performing a triple bypass surgery in Topeka, KS, was reimbursed $3,500. That was the surgeon's fee for performing the operation. If that operation had been performed in New York or Los Angeles, I think the reimbursement rate was about $7,500 for triple bypass surgery.

I would observe that we could fly people from Los Angeles or New York and provide them probably just as good, if not better, care in our modern facilities in Topeka, which is a regional medical center, and save the Federal Government money.

I will give you another example, which is current, and that is for a total hip replacement. The surgeon's fee in Kansas is $2,015.66 today. If you are in Los Angeles, the reimbursement is $3,904 for the same surgery and operating with the same equipment. Probably the medical malpractice rate in Los Angeles is cheaper than it is in Topeka.

Mr. WAXMAN. I doubt that. But the fact of the matter is, whatever the costs are of practicing medicine in Los Angeles compared to Topeka, if malpractice insurance is higher in one place as opposed to the other, or the costs of doing business are higher in one place as opposed to the other, I can't believe it is that much higher.

Mr. SLATTERY. No way.

Mr. WAXMAN. And there is no reason to justify those kinds of disparities.

Mr. SLATTERY. In New York, it is $3,700 compared to the Topeka cost of $2,000. In Nebraska, it is about the same as Kansas, I would observe.

Mr. OWENS. These differences, Mr. Chairman, have developed really historically, using reasons that are not rational and not based on any relationship to the cost of doing business. The cost of a home in Beverly Hills, again—excuse me—is three times perhaps what it is in Salt Lake City, but that should not justify that kind of a difference between the payments.

Mr. WAXMAN. Except for a home.

Mr. OWENS. Even for a home, Mr. Chairman.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

No questions, but I want to commend both our colleagues for, I think, very fine and very thoughtful statements.

It seems to me that what you have done is given us some fresh ammunition with respect to some of these bizarre inequities and distinctions that are built into the way fees are presently paid. We will just be working real closely with both of you. Thank you for your presentations.

Mr. WAXMAN. Mr. Walgren, any questions?

Mr. WALGREN. No questions, Mr. Chairman.

Mr. WAXMAN. We thank you both for your testimony.

Mr. SLATTERY. Thanks a lot.

Mr. OWENS. Thank you.

Mr. WAXMAN. For our next witness, we would like to hear from Dr. Phil Lee, who is chairman of the Physician Payment Review Commission.

Dr. Lee, we are pleased to welcome you back to our subcommittee. Your prepared statement will be in the record in full. We would like to ask you to limit your oral presentation to no more than 5 minutes, and we will have an opportunity for questions and answers.

STATEMENT OF PHILIP R. LEE, CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED BY PAUL GINSBURG, EXECUTIVE DIRECTOR

Mr. LEE. Thank you, Mr. Chairman.

I am delighted, and I am accompanied by Dr. Paul Ginsburg, who is the executive director of the Physician Payment Review Commission.

Let me just say a few words at the outset about the process the Commission has followed. I will review briefly the recommendations, and then we will obviously be available for questions.

Over the last 5 years, we think it has become increasingly clear to physicians, to beneficiaries of payments, and policymakers that the current patterns of relative payments based on customary, prevailing, and reasonable charges has serious problems, and we have just heard from two Members of the Congress about the problems that are evident.

The problems cannot be solved through adjustments in the CPR system; fundamental reform is required. The Commission's proposals for a Medicare fee schedule, expenditure targets, effectiveness research, and practice guidelines described in detail in the testimony, constitute, we believe, a fundamental restructuring of the Medicare physician payment program and a restructuring that would rationalize the payment system, which we think is critical. The proposals and the analyses that underlie them provide the necessary information for Congress to move forward and, we think, to move forward now.

The work on the recommendations that I will present today began more than 2½ years ago when the Commission called for a fee schedule for Medicare and sent out a plan for its development.

Over that period, the Commission has considered both broader conceptual issues that provide the framework for policy and the many technical design issues that are crucial to its implementation. It has conducted an indepth evaluation of the study conducted for the Health Care Financing Administration by Professor William Hsiao at Harvard and his colleagues, and they have developed the real basis for the resource-based fee schedule, for the relative values among procedures and services.

The Commission has drawn heavily on that study and its own analytic work in developing its Medicare fee schedule proposals and has looked at the accompanying policy issues that must be addressed if we are to provide protection for beneficiaries, equity among physicians, administrative simplicity, and control of program expenditures.

Throughout its work, the Commission has sought the input of those who will be affected by the recommendations through surveys of physicians, beneficiaries, and medical carriers, and the use of consensus panels, informal exchanges of information, and formal testimony by organizations representing these groups.

The Commission's annual report submitted to Congress on April 30 provides the basis for Congress to specify the national policy in legislation this year. In that report, the Commission presents proposals to rationalize the payment for physicians and to slow the rate of increase in program costs so that they are affordable to the beneficiaries and the taxpayers. In my testimony, I describe in detail these recommendations and the rationale for that.

I will not discuss the problems that we have examined, but I can tell you that the Commission has looked at a variety of issues and problems, and it is the set of problems but, most fundamentally, the continued rapid rate of increase in expenditures in the Medicare program, 13 percent per year, that requires reform. You can't continue to put that much money into part B and do any of the other things that need to be done. It is for that reason that we felt this combination of recommendations—the payment reform, the expenditure target, and the limits on beneficiary liability—made sense.

Let me just say a brief word about the fee schedule. It would replace the CPR system. It includes the relative value scales which are based on Dr. Hsiao's work with respect to physician work and the Commission's studies with respect to practice costs. Practice costs and physician work are what constitutes the relative values for services. You convert that to a fee schedule with a dollar conversion factor and then deal with the kinds of geographic inequities that we have heard about through the geographic multiplier.

The geographic multiplier would include, in the Commission's recommendation, only practice costs or the nonphysician inputs. It doesn't include the physician cost of living. We think that would provide a more equitable geographic payment system, and that, incidentally, was supported by every physician group that testified before the Commission.

The conversion factor should be revenue neutral. There should be no specialty differentials. Radiology and anesthesiology, which now have separate fee schedules, should be included in the Medicare fee schedule. We will be making coding improvements prior to

full implementation which we think are necessary, things like a global fee for surgical services.

There should be a transition period from the current payment system to the full implementation of the Medicare fee schedule. The Commission recommended that be implemented in 1992 with the transition beginning in April of next year, provided legislation is enacted this year.

To protect beneficiaries, we are recommending—and these are consistent with previous policies established by the Congress—charges for unassigned claims should be limited to a fixed percentage of the fee schedule amount; for example, 125 percent; that is a policy Congress has already adopted with respect to radiology.

Balanced billing should not be permitted for Medicare beneficiaries whose cost sharing is paid by Medicaid, and the PAR program should be continued. Those, we think, are the fundamentals to protect beneficiaries.

The expenditure targets are the most controversial recommendation, and we can get into the details of that in the discussion, Mr. Chairman.

[Testimony resumes on p. 44.]

[The prepared statement of Mr. Lee follows:]

Statement of the
Physician Payment Review Commission

I am pleased to come before the Subcommittee today to discuss physician payment reform and to present the recommendations of the Physician Payment Review Commission. Over the last five years, it has become clear to physicians, beneficiaries, payers and policy makers that the current pattern of relative payments based on "customary, prevailing and reasonable" (CPR) charges has serious problems. These problems cannot be solved through adjustments in the current payment method. Fundamental reform is required. The Commission's proposals for a Medicare Fee Schedule, expenditure targets, effectiveness research and practice guidelines that I will describe today constitute a fundamental restructuring of Medicare physician payment. These proposals and the analyses underlying them provide the information necessary for Congress to move forward.

Establishment of a Medicare Fee Schedule is the logical culmination of the steps that Congress has taken in the past 5 years. In 1986, Congress called for the Secretary of Health and Human Services to develop a relative value scale for physicians' services.[1] It also created the Physician Payment Review Commission to provide the data, analysis and policy advice needed to enact payment reform. And by reducing payments for certain overvalued procedures and increasing payments for primary care and care by rural physicians in the Omnibus Budget Reconciliation Act of 1987, Congress began to move relative payments in the direction of longer-term reform.

The work on the recommendations I will present to you today began more than two and a half years ago when the Commission called for a fee schedule for Medicare and set out a plan for its development. Over that period, the Commission has considered both the broader conceptual issues that provide the framework for policy and the many technical design issues that are crucial to its implementation. It has conducted an in-depth evaluation of the study conducted for the Health Care Financing Administration by William Hsiao and his colleagues at Harvard University to develop a resource-based relative value scale. It has drawn on that study and its own analytical work in developing its fee schedule proposal, and it has looked at accompanying policy issues that must be addressed for payment reform to meet the multiple goals of

[1]Consolidated Budget Reconciliation Act of 1985 (P.L. 99-272).

financial protection for beneficiaries, equity among physicians, administrative simplicity and control of program expenditures.

Throughout its work, the Commission has sought the input of those who will be affected by its recommendations through surveys of physicians, beneficiaries and Medicare carriers, the use of consensus panels, informal exchange of information and formal testimony by organizations representing these groups. There may be differences of opinion on the details of payment reform, but it is clear to us that there is widespread agreement that the problems with Medicare physician payment policy cannot be solved with additional years of incremental changes in the current system, and the time has come for a new national policy.

The Commission's annual report, submitted to Congress on April 30, provides the basis for Congress to specify that national policy in legislation this year. In that report, the Commission presents proposals to rationalize the pattern of payments to physicians by Medicare and to slow the rate of increase in program costs so that they are affordable to the beneficiaries and the taxpayers. In my remarks today, I will describe the Commission's recommendations and the rationales for our decisions.

To rationalize the pattern of payments by Medicare, the Commission proposes a Medicare Fee Schedule based primarily on resource costs. To limit beneficiary financial liability, it recommends limits on balance billing. To control growth in expenditures, the Commission proposes the use of expenditure targets and increased research on effectiveness of medical services and development of practice guidelines.

MEDICARE FEE SCHEDULE

The Commission proposes that the current CPR method for paying physicians be replaced by a Medicare Fee Schedule that is based primarily on resource costs. The Commission recommends enactment of legislation this year to establish a Medicare Fee Schedule, with a transitional stage beginning in 1990 that

moves the payment system in a series of steps toward full implementation of the Medicare Fee Schedule in 1992. The Commission also recommends that the Medicare Fee Schedule should be used to determine payment to physicians in all specialties, including radiology and anesthesiology which are currently paid under specialty-specific relative value scales.

A fee schedule consists of:

- a relative value scale (RVS), which indicates what a service or procedure is to be paid relative to others,
- a conversion factor, which translates the RVS into a fee for each service, and
- a geographic multiplier, which indicates how payment for a service is to vary from one geographic area to another.

Relative Value Scale

The Commission has reached a number of conclusions about the design of the relative value scale for the Medicare Fee Schedule. I will briefly describe our recommendations and then provide some background for the Commission's decisions.

The Commission recommends that the relative value scale (RVS) be comprised of two cost elements: relative physician work (time and effort) and practice costs (costs of nonphysician inputs).

With respect to relative physician work, the Commission favors:

- the use of the Hsiao methodology for estimating relative physician time and effort as the initial basis for the physician work component in the relative value scale,

- adoption of a policy developed by the Commission to standardize the definition for all surgical global services, and

- modification of the current coding system for evaluation and management services to incorporate time into the definition of visit codes.

For practice costs, the Commission proposes:

- use of a Commission-developed additive formula for incorporating practice costs into the RVS,

- initial use of the Commission's refined estimates of practice costs by specialty, to be superceded by estimates of practice costs by category of service, and

- development of a separate practice cost factor for professional liability insurance premiums.

Relative Physician Work. The Commission has carefully evaluated the pioneering work by William Hsiao and his colleagues at Harvard University to develop a resource-based relative value scale. As have others, the Commission has found the methodology for estimating relative physician work to be sound and has drawn heavily on it in developing its RVS for the Medicare Fee Schedule. The Commission's evaluation calls for additional research to be undertaken by Dr. Hsiao and the Commission staff to strengthen the results of the study. Most of these tasks are already underway.

A national fee schedule requires that the codes for physician services be interpreted uniformly by all physicians and carriers. Only then can accurate relative values be assigned to each service so that fees reflect the resource costs associated with providing that service. The Commission's recommendations call for changes related to coding in two important areas: surgical global fees and evaluation and management

services.

Codes for Surgical Global Services. With the unanimous agreement of a consensus panel made up of surgeons and carrier representatives, the Commission has developed a policy defining which services associated with an operation are to be included in the global payment for surgery and which are to be paid separately. The Commission recommends that this policy be adopted by all Medicare carriers when the Medicare Fee Schedule is implemented.

Codes for Evaluation and Management Services. Physicians cannot accurately use the current codes for evaluation and management services (commonly referred to as visit codes) to reflect their time and work, because the levels of service (e.g., brief, intermediate, comprehensive) are not precisely defined. Therefore, it is difficult to assign accurate values to current visit codes in a resource-based fee schedule.

Analysis by the Commission and by Dr. Hsiao and his colleagues suggests that the physician's time is a good predictor of the work involved in each type of visit (e.g., hospital visit, office visit, new patient, established patient). The Commission recommends that time be incorporated into the definitions for visit codes. This coding reform would allow more accurate relative values to be assigned to these services and help physicians use the codes properly. Carriers would also have a way to determine whether physicians were billing correctly for these services.

With work currently underway by the Commission, Dr. Hsiao and the AMA-sponsored CPT Editorial Panel that oversees the CPT coding system, we expect definitions for visit codes to be revised and individual relative values to be assigned within the next year, well before full implementation of the Medicare Fee Schedule.

Grouping of Codes. Given the work currently underway to modify the coding system for the Medicare Fee Schedule, the Commission recommends the postponement of the legislative mandate to "group codes for

payment purposes" by January 1, 1990.[2] The goal of this mandate is to control misuse and abuse of the coding system under the current payment method. Analysis by the Commission suggests that this could be accomplished more effectively by integrating precise definitions for codes with relative values that more closely approximate relative resource costs.

Practice Cost Formula. The Commission has developed a formula for incorporating practice costs into the RVS that allows for overhead to be calculated independently from physician work. The original formula developed by Dr. Hsiao maintained the same ratio of the valuation of physician work to practice costs for each service under the resource-based relative value scale as under CPR payment. This distorted relative values and led to an overestimate of the impact of the fee schedule on different specialties. As a result of the Commission's correction in the formula, the magnitude of changes in fees and impacts on different specialties is almost halved from the preliminary estimates reported by Dr. Hsiao and his colleagues last summer.[3]

Professional Liability Insurance. Insurance coverage for professional liability represents a major cost to physicians that varies substantially by specialty and geographic area. To assure that the fee schedule adequately accounts for differences among risk classes (e.g., physicians doing no surgery versus thoracic, vascular and orthopedic surgeons) and localities (e.g., Florida, Idaho) used in setting premium rates, the Commission recommends that professional liability insurance premiums should be separated from other practice costs. They can either be integrated into the RVS through a separate practice cost factor or be reimbursed directly to physicians.

Updating the Relative Value Scale. Revisions in the relative value scale will be required to account for the introduction of new technology, changes in the use of existing technology and in clinical approaches to care,

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[2]Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Section 9331 (d)(2).

[3]Hsiao, et al., "Results and Policy Implications of the Resource-Based Relative Value Study," The New England Journal of Medicine, 319 (13): 881-888 (September 29, 1988.

and refinements in the coding system. The Commission recommends that the process used to develop the Medicare Fee Schedule, in which the Commission provides the Congress with the information and advice it needs to make policy decisions, be used for updating the relative value scale. That process has been successful in accomplishing the technical and policy development tasks required and is structured to provide substantial opportunity for organizations representing physicians, beneficiaries and others affected by the policy to participate in the decision-making process.

Conversion Factor

The conversion factor transforms the RVS into a schedule of dollar payments for each service. The Commission has assumed that the initial conversion factor would be set so that outlays for physicians' services projected under the fee schedule would equal those projected under the current payment system. This "budget neutral" conversion factor for the initial year would separate the fundamental reform embodied in the Medicare Fee Schedule from aggregate budgetary concerns that could be addressed separately through an update in prevailing charges. With this update in place, fees under the Medicare Fee Schedule would be established using a budget neutral conversion factor.

The conversion factor should be updated annually. The updates would be based on expenditure targets that I will describe in more detail in a moment.

Geographic Multipliers

The Commission recommends that the geographic multiplier reflect only variation in overhead costs of practice. The amount physicians receive for their time and effort, after subtracting overhead costs, should not vary by locality. Therefore, if physicians in two parts of the country provide the same quantity and mix of services to Medicare beneficiaries, they would receive the same net income from Medicare. This policy

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would reduce substantially the magnitude of geographic variation in fees. Also, as part of the Medicare Fee Schedule, a uniform policy on the delineation of charge localities should be established.

Specialty Differentials

The Commission recommends that when a service provided by physicians in different specialties is essentially the same, the payment should be the same. Therefore, specialty differentials -- differences in payment to physicians of different specialties for the same procedure code -- would be eliminated under the fee schedule.

In some cases, physicians in different specialties provide different services under the same code, and yet receive the same payment, because distinct codes that would accurately capture these differences do not exist. These legitimate differences, when substantiated, should be recognized by establishing new codes. Identification of such coding changes would be part of the process for updating the relative value scale.

Assignment and Balance Billing

The Medicare Fee Schedule must be accompanied by policies to limit beneficiaries' financial responsibility for charges in excess of what Medicare allows. The Commission does not recommend mandatory assignment but proposes the following set of policies that together provide increased protection for beneficiaries:

- charges for unassigned claims should be limited to a fixed percentage of the fee schedule amount. These charge limits would replace current MAAC limits. Federal legislation in recent years has set two precedents for the amount of balance billing allowed. In one (overpriced procedures), the charge limit, after a phase-in period, was set at 125 percent

of the Medicare allowed amount; in the other (the radiology fee schedule), the limit will be phased in to 115 percent.

- balance billing should not be permitted for any Medicare beneficiary whose cost sharing is paid by Medicaid.

- the Participating Physician and Supplier Program (PAR) and its payment differential that provides higher fees to participating physicians should continue under the Medicare Fee Schedule.

The Commission has concluded that the market for physicians' services does not function well enough to preclude the need for financial protection for Medicare beneficiaries. Without limitations on balance billing, beneficiary financial protection would suffer. On the other hand, the Commission does not recommend mandatory assignment. Mandatory assignment would be unacceptable to many physicians and inconsistent with the Commission's goal of orderly change.

Impact on Physicians and Beneficiaries

The Commission has constructed simulation models to project the impact of the Medicare Fee Schedule on categories of physicians and beneficiaries. Table 1 shows the changes in Medicare payments for selected services. Note that fees for evaluation and management services, such as office visits and hospital visits, would increase and fees for many surgical procedures would decrease. Table 2 shows the impact on major specialties included in the first phase of the Hsiao study. Medicare payments would increase substantially for family physicians and internists and decrease substantially for thoracic surgeons, ophthalmologists, and radiologists. Some surgical specialties, such as urology, otolaryngology and orthopedics, would have small net changes, with increased fees for evaluation and management services roughly offsetting declines in fees for surgical procedures.

The Medicare Fee Schedule would change the distribution of payments among geographic areas (Table 3). Using a geographic multiplier that reflects overhead costs only, payments to physicians in rural areas would increase by 14 percent. Those to physicians in very large metropolitan areas would decrease by 14 percent. Payment changes in other categories of metropolitan areas would be small. The magnitude of payment variation from one locality to another would be substantially less than under current policies.

Table 4 shows the impact on beneficiary out-of-pocket payments for coinsurance and balance bills for different categories of beneficiaries. All of the categories identified would experience a moderate reduction in costs, most of which would result from the limit on balance billing. Indeed, the percentage reductions in balance billing alone are much larger. The magnitude of these reductions is relatively uniform across the different categories of beneficiaries.

Transition

The Commission recommends a transitional stage from the current payment system beginning in 1990, with full implementation of the Medicare Fee Schedule in 1992. One transition plan that would meet these objectives would initially retain customary and prevailing charge screens in the transitional stage. For each charge locality, a projected fee schedule amount would be calculated for each of 350 services and procedures that account for the largest volume of Medicare claims. For each service/locality combination, the percentage difference between the fee schedule amount and the average allowed charge under current policy would be calculated. In the case of evaluation and management services, however, where accurate relative values for individual codes will not be available until coding is reformed, the calculation of percentage differences would be for categories of services.

For the first year of the transitional fee schedule, the prevailing charge for each procedure would be changed by one-fifth of this percentage difference. Thus, for example, if office visits are to increase by 28 percent under the Medicare Fee Schedule, the prevailing charge for each type of visit would increase by 6 percent

during the first year. For the second year of the transitional fee schedule, prevailing charges would be adjusted by an additional one-fourth.

Implementation of the transitional fee schedule would begin six to nine months after enactment of the legislation. After two years of experience, the full Medicare Fee Schedule would be implemented. At this point, coding reforms and changes in locality boundaries would be implemented.

POLICIES TO SLOW INCREASES IN EXPENDITURES

From 1980 to 1988, Medicare outlays for physician services tripled. Premiums now amount to $334.80 per year. Neither the taxpayers or the beneficiaries can afford continued increases of this magnitude. Decisive steps to slow these increases are needed now. The preferred way to contain costs is to reduce the provision of those services that are unnecessary and inappropriate. In this way, access and quality of care would not be sacrificed in the course of slowing expenditure growth.

The Commission recommends that three policies be pursued:

- giving physicians collective incentives to contain costs through expenditure targets,
- increased research on effectiveness of care and development and dissemination of practice guidelines,
- improvements in utilization management by carriers and peer review organizations (PROs).

Expenditure Targets

The Commission recommends that a national expenditure target for physicians' services under Part B be used to determine annual conversion factor updates under the fee schedule. The target would reflect increases in practice costs, growth and aging of the enrollee population, and a decision concerning the appropriate rate of increase in volume of services per enrollee. The last would reflect tradeoffs between beneficiary needs, technological advances, and affordability.

If actual expenditures during a year are equal to targeted expenditures, then the conversion factor update for the following year would be equal to the increase in practice costs. The update would be increased or decreased to reflect differences between actual and targeted expenditure increases.

As an example, assume that practice costs will increase by 4 percent, enrollment and aging will increase expenditures by 2 percent, and volume of services is projected to increase by 7 percent per enrollee. This would lead to a 13 percent increase in expenditures. Now assume that a target of 11 percent is chosen, which would permit a volume increase of 5 percent. If actual expenditures rise 13 percent, then the conversion factor update for the following year would be 2 percent (the 4 percent increase in practice costs less the 2 percent by which the target was exceeded). If actual expenditures rise only 9 percent, then the conversion factor update would be 6 percent (the increase in practice costs of 4 percent plus the 2 percent by which expenditures fell short of the target).

Expenditure targets are designed to stimulate efforts by the medical community to work with the Medicare program to increase knowledge of the effectiveness of services and to use this knowledge to increase the appropriateness of care. Encouragement would come from tying the annual update in the Medicare Fee Schedule conversion factor to the difference between the rate of increase in expenditures for physicians' services and the target rate of increase.

In order to allow time for the necessary infrastructure to control costs to develop, the Commission suggests a cautious approach to setting the target rates of increase for the first few years.

The Commission recommends beginning with a single target at the national level, but expects that the policy will evolve to incorporate a broader range of services and to multiple targets. Over time, the scope of expenditure targets could be broadened to include other Part B services that are ordered by physicians and the rate of hospital admissions. Targets could be established for states, carrier areas or metropolitan areas. In addition, targets could be developed for categories of medical services. The Commission has already studied several of these options and will continue to do this work.

Expenditure targets would not alter the financial incentives for individual physicians and their patients. Rather, the incentives would fall to the physician community, which could respond through education and support of the existing infrastructure of medical review. For example, the American Medical Association and national specialty societies could develop practice guidelines and disseminate them. They could provide technical assistance to carriers and PROs in the development of criteria for review and political support for sanctions of physicians who persisted in providing care that is inappropriate and does not meet standards of quality.

Effectiveness Research and Practice Guidelines

The Commission recommends a substantial increase in federal support for building our knowledge of the effectiveness and appropriateness of medical practices and getting that knowledge to practicing physicians and their patients. We need to know more about which of our diagnostic tools work, and which patients would benefit from particular therapy. This knowledge is essential if we are to reduce unnecessary and inappropriate services.

To increase this knowledge, we need more research to determine the medical outcomes and the costs of alternative medical practices and procedures, and to determine the best ways to organize and provide care. This work would include clinical trials, epidemiological studies of data generated by clinical practice, analyses of the cost-effectiveness of alternative ways to organize care, and assessment of techniques used in managed care to influence physicians' clinical decisions.

The knowledge we have about effectiveness and appropriateness must be made available to physicians and their patients. Practice guidelines synthesize the best that we know from research and the judgments of practicing physicians, into a form that can be readily used. The Commission recommends that the federal government actively encourage the development and dissemination of practice guidelines so that they are incorporated into physicians' practices, made available to patients, used as the basis for coverage and payment decisions, and incorporated into the medical review criteria of hospital medical staffs, carriers, and PROs.

The Commission calls for the federal government to support practice guidelines through funding, coordination and evaluation. Funds should be used to support and build on existing private sector activities by the medical profession and others. Federal oversight should focus on insuring the integrity of the process, including the quality of the methods used and of the resulting guidelines, and facilitating efforts to share information, identify issues and set priorities.

The federal government also has a role as administrator of Medicare. The Health Care Financing Administration should reinforce the importance of basing medical review on sound criteria by assisting PROs and carriers in selecting and using review criteria that are consistent with practice guidelines.

Utilization Review

The Commission supports the current efforts by HCFA to move toward a more comprehensive approach

to medical review and calls for further actions to strengthen the review process.

If utilization and quality review are to be effective tools both to improve the quality and efficiency of care and to control the growth in Medicare expenditures, the Medicare program will have to create a comprehensive medical review system that looks beyond individual services to complete episodes of care. This requires systematic integration of information drawn from claims data, analysis of practice variations and peer review of physician practice.

To take on these responsibilities, it is essential that carriers and PROs have additional resources and time to build the necessary capacity. It will also require more administrative flexibility and the cooperation of the medical community. The Commission report presents a number of specific recommendations to structure and focus the transition from the current system that has emphasized claims payment to one of comprehensive review.

INFRASTRUCTURE FOR PAYMENT REFORM

Successful implementation of the payment reforms described above will require investments in the administrative infrastructure of Medicare. We applaud recent efforts by HCFA to introduce a unique physician identifier, to incorporate diagnostic information on claims forms, and to develop a common working file including data from both Part A and Part B.

The Commission recommends two further changes to strengthen the ability to implement these payment reforms. First, Medicare should require providers to submit all claims, whether or not assignment is accepted. Second, HCFA should take steps to accelerate the trend towards electronic claims submission. The ability of the carriers to implement a fee schedule and expand their medical review activities is dependent on funding that is adequate and predictable. Unfortunately, this cannot be taken for granted. While funding for medical review activities of carriers was increased for the current fiscal year, the President's

budget for 1990 would cut funding by 19 percent. In a program trying to hold back outlay increases in the range of $4 billion per year, attempts to shave spending for administration (in particular, medical review) are poorly conceived. If we are to attempt major reforms in this program, we must assure that the administrative resources are there to carry them out.

CAPITATION

Some have expressed concern that certain types of prepaid health plans have failed to establish strong organizational structures and management systems and instead have relied heavily on financial incentives to physicians to control costs, posing a risk of underservice to enrollees. This concern led Congress in 1986 to prohibit HMO and CMP use of financial inducements to physicians to reduce or limit service to Medicare beneficiaries. The provision was not scheduled to take effect until 1990 in order to permit time to substitute a less sweeping limitation.

While use of financial incentives to physicians raises important concerns regarding patient care, broad prohibitions may not be in the interest of Medicare beneficiaries. First, we have no definitive information concerning whether or not risk-sharing arrangements now have an adverse effect on access or quality. Second, such restrictions could result in the termination of many HMOs' risk contracts with Medicare and reduce beneficiaries' access to prepaid plans. Medicare beneficiaries comprise a very small proportion of HMO enrollment, so restrictions on practices that HMOs consider important to their success could lead many to turn away from the Medicare program.

The Commission has developed proposals to restrict only the more problematic forms of financial incentives. It recommends that health plans limit the total risk assumed by physicians through some form of reinsurance or "stop loss" provision and that they rely primarily on incentives to groups of physicians rather than to individual physicians. Health plans should also disclose to both physicians and enrollees appropriate information on risk-sharing arrangements.

In addition to limitations on the use of financial incentives, the Commission recommends efforts to strengthen Medicare's external review processes applicable to prepaid plans and the conduct of periodic surveys of beneficiary satisfaction. Finally, the Commission recommends additional research to identify the effects of patient characteristics on the use of services and on the impact of risk-sharing arrangements on physician behavior.

CONCLUSION

Three years ago, Congress created the Commission with a mandate to suggest policies to rationalize payments for physicians' services and to slow the rate of growth of expenditures for these services. We now have the information necessary to develop the types of legislative reforms the Congress envisioned when it established the Commission. We believe that a Medicare Fee Schedule will serve to rationalize payments by tying them to resource costs. It will be simpler and easier to understand for both physicians and beneficiaries. It will promote better care and provide additional financial protection for beneficiaries. Expenditure targets will help slow the increase in Medicare expenditures so that we as a society can meet other pressing social needs. And increased effectiveness research and practice guidelines will provide us with the knowledge and means to manage available health care resources more wisely. With these changes, we believe that Medicare can continue to meet the medical needs of our elderly and disabled citizens.

Table 1. National Mean Payments for Selected Procedures

		CPR	MFS	Change
Evaluation and Management		$	$	%
90050	limited office visit	23	28	24
90060	intermediate office visit	28	35	26
90250	limited hospital visit	26	33	28
90260	intermediate hospital visit	30	40	34
90620	comprehensive consultation	93	104	12
92014	eye exam and treatment	42	39	-6
Surgery				
27130	total hip replacement	2404	1985	-17
27244	repair femur fracture	1299	1198	-8
33512	coronary artery bypass	3894	2828	-27
35301	rechannel of artery	1573	1172	-26
44140	partial removal of colon	1256	1072	-15
49505	repair inguinal hernia	588	414	-30
52601	prostatectomy (*TUR*)	1128	921	-18
66984	remove cataract, insert lens	1164	1164	-21
Diagnostic				
52000	cystoscopy	105	110	5
70470	contrast CAT scans of head	113	82	-27
71010	x-ray exam of chest (1 view)	12	10	-16
93000	electrocardiogram, complete	35	25	-28

Source: PPRC Simulations.

Note: Fees are for procedures performed by the most common specialty in the most common place of service.

Table 2 Change in Medicare Payments[a] by Specialty Medicare Fee Schedule

SPECIALTY	PERCENT CHANGE
Medical	20
Internal Medicine	17
Family Practice	38
Dermatology	1
Surgical	-11
Ophthalmology	-16
General Surgery	-10
Orthopedic Surgery	-7
Urology	-5
Thoracic Surgery	-20
Otolaryngology	6
Obstetrics/Gynecology	2
Hospital Based	*(na)*
Radiology	-21
Pathology	-25
Anesthesia	*(na)*
Other Physicians[b]	4

Note: [a] Does not include balance bills.

[b] Other Physicians includes physician specialties with data problems and were not evaluated in the Hsiao study: cardiovascular disease, clinic, general practice, gastroenterology, nephrology, neurology, neurosurgery, plastic surgery, psychiatry, and pulmonary disease.

Table 3. Change in Payments by Geographic Area Medicare Fee Schedule

AREA[a]	SPECIALTY GROUP	PERCENT CHANGE
Very Large Metro		
	Medical	-1
	Surgical	-25
	All physicians	-14
Large Metro		
	Medical	17
	Surgical	-12
	All physicians	-3
Small Metro		
	Medical	26
	Surgical	-7
	All Physicians	3
Large Rural		
	Medical	30
	Surgical	-6
	All Physicians	12
Small Rural		
	Medical	37
	Surgical	-7
	All Physicians	14

Note: [a] Very Large Metro areas include counties in MSAs of 5 million or more populations; large metro includes counties in MSAs of 1 million to 5 million population; small metro area are all other metropolitan counties. These areas accounted for 14, 37, and 33 percent respectively of Medicare allowed amounts in 1988. Large rural (non-metropolitan) counties have population of 25,000 or more; small rural includes all other non-metropolitan counties. These areas accounted for 9 and 7 percent, respectively of Medicare allowed amounts in 1988.

Table 4. Beneficiaries' Liabilities for Coinsurance Plus Balance Bills Under the Medicare Fee Schedule

120% Balance Bill Limit

	DOLLARS OF SPENDING PER BENEFICIARY AND PERCENT CHANGE FROM CPR					
	TOTAL		BALANCE BILL		COINSURANCE	
All	$179	-25%	32%	-65%	$147	0%
< 65 yrs	186	-21	24	-69	182	3
65 - 74	167	-27	32	-65	135	-2
75 - 84	195	-24	35	-63	160	0
85+ yrs	184	-19	29	-64	155	5
Males	190	-26	34	-65	156	-2
white	192	-26	36	-65	156	-2
non-white	170	-18	18	-67	152	0
Females	171	-24	30	-65	141	1
white	172	-25	31	-65	141	1
non-white	157	-16	17	-67	140	3
Area[a]						
very large metro	219	-32	36	-69	183	-12
large metro	196	-23	31	-65	165	-1
small metro	175	-25	33	-64	142	1
large rural	158	-24	30	-65	129	3
small rural	151	-25	31	-64	120	6
Income (% poverty level)						
below	153	-21	24	-65	129	4
100 - 149%	161	-24	29	-64	133	1
150 - 199%	168	-23	30	-64	138	2
200 - 299%	183	-24	33	-64	150	1
300% and over	191	-28	37	-64	154	-3
Hospitalized						
yes	452	-25	79	-66	373	1
no	97	-25	18	-63	79	-2

Source: PPRC Simulations.

Note: Excludes enrollees who did not have claims and Medicaid beneficiaries.

[a] Areas are assigned by beneficiary's residence. Very Large Metro areas include counties in MSAs of 5 million or more population; large metro areas include counties in MSAs of 1 million population; small metro area are all other metropolitan counties. Large rural (non-metropolitan) counties have population of 25,000 or more; small rural includes all other non-metropolitan counties.

Mr. WAXMAN. Thank you very much, Dr. Lee.

Since we set up the Commission and asked that you work with the various professionals in the medical community, that you review the Hsiao study, and try to come up with some recommendations to us, could you describe for the record what kind of process you have in terms of hearings, what kind of consultation would you have with the various groups that are interested in this issue.

Mr. LEE. The first thing we did, Mr. Chairman, when I was appointed in the summer of 1986 was to secure an appropriation. That was done fairly promptly. We then recruited staff early in the fall of 1986 and began, in November of 1986, with public hearings. We were able to start almost immediately after the appropriation, because we had been able to recruit staff very early.

We have held public meetings, six or eight a year, since that time. We have had one or two additional public hearings each year to hear testimony, in some cases from all the specialty groups, on the Hsiao study, for example.

We circulated drafts of our reports, drafts of chapters, drafts of materials under consideration by the Commission, to various interest groups—beneficiaries, carriers, and various physician specialty groups, and the AMA. The staff has really, I would say, had probably hundreds of meetings with various staffs of physician specialty groups. Many of the Commissioners have met individually. Everything we do has been public. Every document we have produced has been available for public consideration. There have been a number of analytic studies which have also been circulated for comment and review. There have been simulation studies. There have been meetings with HCFA with respect to both the analytic studies and also implementation issues.

So, in short, Mr. Chairman, there has been an extensive network of open public hearings, consultations, circulation of documents prior to the Commission's making its recommendations.

Mr. WAXMAN. To what extent are your recommendations reflective of a consensus of the interested parties? Is there a consensus there, and is the level of support based on the view that it is clearly a better alternative than the status quo, or is it based on the self-interested view of the various groups that are involved?

Mr. LEE. Let me start first with the Commission itself, which includes six physicians and seven nonphysicians. It includes individuals representing beneficiaries, such as Jack Gildroy, who is on the board of the AARP; it includes two family practitioners, one from rural Texas, one from Portland, OR; it includes three economists; it includes a former president of Blue Cross—a wide spectrum of views represented on the Commission.

The Commission reached consensus on every recommendation with one exception. Four members of the Commission recommended mandatory assignment when the fee schedule was implemented and submitted a minority report. On all the other recommendations, the three major recommendations, there was consensus.

Within the interest groups, the medical profession is the one most affected. The AMA has supported, in principle, the resource-based relative value scale and has been a subcontractor with the Hsiao study. The House of Delegates—and I am sure you will hear from the AMA later this morning—has not specifically dealt with

the Commission recommendations, so that we don't have yet a clear sense of where the various medical specialty groups and the AMA come out with respect to our recommendations.

I would say that the payment reform generally has the support of the AMA, the Academy of Family Practice, the College of Physicians, and you will hear from those groups later today, so you will hear directly from them. The expenditure targets do not have the support of the medical profession. There is concern about that, but I believe that our rationale for it was really twofold: One, when you have a payment reform of the magnitude that we are recommending, as an insurance with respect to expenditures, you must have, we believe, an expenditure target, a national target established by the Congress.

We also believe that the expenditure target will provide a significant collective incentive for physicians to deal with a serious problem that was identified for the Commission, namely, the inappropriate services that are being provided, somewhere between 20 and 30 percent perhaps, services that are of marginal benefit or of no benefit to patients.

Mr. WAXMAN. One of the most significant revisions you made in the Hsiao analysis was a reconfiguration in the treatment of practice costs. Is there general agreement with that change, and what can you tell us about Mr. Hsiao's views? Does he concur in your revision?

Mr. LEE. I think that there is general agreement with our approach to practice costs. As we reviewed the Hsiao method, which used practice costs and multiplied those times work, we found that in looking at more current data—and Hsiao looked at 1983 data; our staff has looked at more current data—there is, I think, widespread support for the Commission's approach to practice costs, that methodology, and I believe that Dr. Hsiao is probably supportive of that now as well.

Paul, would you want to say a word abut that?

Mr. GINSBURG. Yes. I can say that when Dr. Hsiao testified at the Senate Finance Committee he included in his testimony some estimates of impacts which reflected a change in the formula consistent with the way the Commission did. So I would say that he is at least 95 percent in support of the changes.

Mr. WAXMAN. Earlier this week, HCFA released some preliminary charts showing the potential impact of implementing an RBRVS fee schedule under certain assumptions. Have you had a chance to review that information, and do you have any comments?

Mr. LEE. The staff has reviewed that, Mr. Chairman, and the Commission will be reviewing that at the meeting next week, June 1 and 2. I have had, myself, a chance to look at it very, very briefly. It seems to me that what it primarily reflects is the problems that were identified in earlier testimony today. There are gross inequities in payments currently with the CPR system by geographic area. That analysis didn't show the inequities by specialty, but there are equally serious inequities by specialty, because some carriers include specialty differentials and others do not. So, to me, it reflects primarily the inequities in the current payment system.

Paul, do you want to comment on that also?

Mr. GINSBURG. Yes. I would like to add something. The general pattern showed by the HCFA analysis appears to be consistent with the Commission's data, but I would caution people that the projections for some individual localities may be in error. Some of them look suspect. The unfortunate thing is that the data that we all use to do analyses like this aren't perfect, and when we start looking at very specific areas sometimes problems can come up. These problems tend not to appear when we look at the broader areas. So I am planning to have my staff meet with HCFA to try to identify, as soon as we can, which ones of the specific results appear to be problematic and caution people not to rush to conclusions based on that.

Mr. WAXMAN. Thank you.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Dr. Lee, I think you heard me say earlier I am particularly concerned at this point about how all of this would affect access, because we have got somewhere between 37 and 40 million people without access to care. The consequences are seen all the way through the system from the standpoint of cost shifting and the like.

I would like to first ask, what analyses have been done to determine how the Commission's work, how the Commission's proposal, would affect access or availability to care in this country.

Mr. LEE. There are two sides to that question. One is, what effect it will have on Medicare beneficiaries, who currently have excellent access, and would it adversely affect that or would it provide access to more appropriate care?

We believe that the recommendations that the Commission has made will, in fact, make access to more appropriate care more available. Currently, there is very good access to care by beneficiaries. Our beneficiaries survey indicated that less than four tenths of 1 percent of beneficiaries were denied care for financial reasons. Less than 4 percent, or about 4 percent, experienced financial difficulty. Now that is extraordinary when you consider the financial condition, the number of elderly who live in poverty. That is dramatically different than Medicaid, and it is dramatically different than the uninsured.

If you implemented the recommendations of the Commission, you would generate $4 billion of savings by 1994; $4 billion of savings would make a significant contribution to buying into Medicaid for those currently below the poverty line. So that decisions with respect to Medicare payment to physicians can have a direct effect on access to millions of others.

If, for example, there was an employer-mandated provision that included everyone who worked below 25 hours a week, if you then had $4 billion to insure Medicaid beneficiaries, you would bring in most of the individuals currently uninsured below the poverty line, below 100 percent of poverty, so that you could make significant impact if these recommendations were adopted.

Mr. WYDEN. Let me make sure I follow this, because no one has questioned whether senior citizens are eligible for the Medicare program. Senior citizens are eligible, and that certainly constitutes universal access for people over the age of 65.

But your thesis is that, as a result of what you are proposing, something like $4 billion would be saved and that, in effect, would be money that could be used for various kinds of programs for uninsured, Medicaid buyins, and the like, and it is that analysis that you have done which would suggest that on the access point, specifically, we would generate significant sums of new money to expand access to the uninsured.

Mr. LEE. The primary reason the Commission voted for the expenditure targets was that there would not be money available to do other things that need to be done unless you control the rate of increase in part B expenditures. That was the fundamental reason. What Congress decided to do with that money, obviously, is Congress' decision, and we really didn't consider that. We only considered that we couldn't do those things if you didn't have those kinds of savings.

Mr. WYDEN. That was really my next point, because it seems to me, to generate the additional revenue, there is no way to do that without the expenditure targets, and I appreciate knowing that for the record.

If you don't go with the expenditure target concept, what do you think of the argument that this really isn't anything more than redistributing the wealth among the specialties? That has been a criticism that I am sure you have heard. Some have said, well, some specialties get more, other specialties get less. Is that a fair criticism unless you have the expenditure target, which really generates a savings?

Mr. LEE. The Commission's view about that is that we were not primarily concerned with equity among physicians. That was one of the issues, but it was a lower priority issue. We felt that you had to rationalize the payment system. The current incentives in the payment system now seriously distort the services that are provided, and also they provide incentives to due procedures, for example. An electrocardiogram is paid higher by Medicare currently in many carrier areas than an intermediate hospital visit. Well, that doesn't make any sense. There are tremendous incentives, distorting incentives, in the present payment system.

Rationalizing the system, we think, is the most important result of the payment reform that is being proposed. The same amount of work would receive the same amount of pay with the new system. Now the fact that that would correct serious inequities is a result of that but not the reason for doing it. The Commission was not particularly concerned that ophthalmologists have a higher income than general practitioners.

Mr. WYDEN. Is it your view that enough is known at this point, that Congress should act to begin implementing this proposal? In other words, we will hear testimony today from a variety of people, I think, who will say we need to do more research and the like, but we have, as you know, a budget process that comes up very shortly, and the question will be, do we know enough today to begin, over a 4- or 5-year period, to implement this? Is it your view that we do?

Mr. LEE. We think absolutely that the Congress does, and every year that you delay you are simply costing billions of dollars downstream. Every year you delay it, those savings downstream get delayed, and there is very adequate information now on which to de-

velop legislation to establish the policies and to have a fee schedule implemented perhaps by 1992, as the Commission has recommended.

Mr. WYDEN. May I ask one more question, Mr. Chairman? I know my time is up.

Mr. WAXMAN. Yes.

Mr. WYDEN. With respect to the low-income older person, you have recommended that Medicare payments be accepted as payment in full, that there be no balance billing. Was there any administrative mechanism that you proposed for doing that? Is this some kind of means testing concept, or how would you propose doing that?

Mr. LEE. The Commission opposed means testing. It was only for those beneficiaries that had a Medicaid buyin. So when they are Medicaid eligible, there is no balance billing. That is the determination.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Walgren.

Mr. WALGREN. Thank you, Mr. Chairman.

Was there consensus among the various groups on the specialty differential, that there should be no differential between specialties?

Mr. LEE. The bulk of the testimony that the Commission received supported the Commission's recommendation. There is concern by some medical subspecialties—infectious disease, endocrinology, rheumatology—that they might not be fairly treated because of the complexities of the patients that they diagnose. But I would say the bulk of the testimony we received supported that recommendation.

Mr. GINSBURG. If I can add something, one important aspect of the Commission's recommendation that there not be specialty differentials is that there be reform in the coding for visits and consultations. The data we have seen indicate that for the same code often a subspecialist—say, a rheumatologist—will spend a lot more time with a patient than a family physician and that a reform in coding which would incorporate time into the definitions of the various codes would redress that and would permit elimination of specialty differentials that might have been useful under today's interpretation of coding.

Mr. LEE. And we are undertaking those studies now, and they will be completed. We are doing a survey, a log diary survey, of physicians. We will then have a consensus panel of physicians who will work with us to examine and make recommendations with respect to those codes.

Mr. WALGREN. You say in your testimony that when a service provided by a physician in different specialties is essentially the same the payment should be the same. Would that also cover the general practitioner that Congressman Slattery raised?

Mr. LEE. Yes.

Mr. WALGREN. You seem to be saying differences between specialties, but here we have differences between a specialist and a general practitioner. But, in your view, the approach should be that there be no difference between those two comparisons either.

Mr. LEE. When they properly code and they code for the same service, then the payment should be the same.

The specialist may code—I mean if they spend more time with a patient, with the revised codes that we will develop, a patient who requires more time, the coding would indicate that. It would be, let's say, an intermediate visit instead of a limited visit.

Now, physicians may code those—an internist may see a patient, a general practitioner may see a patient, one may code it differently than the other, and different carriers will interpret those codes differently, so that there is a great deal of confusion now, and we think that the time as a modifier is going to help to solve that problem.

But the general practitioner and the internist, if they did the same thing with the same code, they would get the same pay.

Mr. WALGREN. How does the expenditure target work? I gather there was not consensus on the expenditure target. One concern is, I guess, how does the individual physician relate to an expenditure target? He can't change the volume of his own practice. How would that be implemented?

Mr. LEE. Our view is, with the national expenditure target, which would include all physicians, that the incentives for physicians are then to control the rate of increase in the volume of services. Because there is a significant percentage of those services that are unnecessary, we are hoping that the physicians, through their various specialty societies, through the hospital utilization review committees, as well as working with carriers and with PRO's, will develop practice guidelines, will have a clear set of guidelines as to what is appropriate and what is not appropriate.

There is a lot of uncertainty now with respect to, what do you do in an individual situation? With practice guidelines, there will be some clear parameters that the physicians can follow in deciding what to do and what not to do.

We think that the incentives will be a collective incentive for all physicians to deal with these inappropriate services and to deal with the utilization problems which absolutely exist; there are very serious problems, and they are not being dealt with at the present time.

Mr. WALGREN. But how does it work when you set a national expenditure target but the physician sees individuals coming through the door and he is expecting, I gather—has a right to expect—a certain amount of reimbursement for any particular service he delivers? How does that relate to a national target if the cumulative expenditures of all the individuals adds up to more than the national target?

Mr. LEE. We did not want the individual physician to have to be making those decisions. We want those to be collective decisions about appropriateness. Those get then translated.

Mr. WALGREN. Translated how?

Mr. LEE. Into changes in practice behavior and reducing the volume of inappropriate services.

Mr. WALGREN. And how is that translated?

Mr. LEE. That would be translated in, for example, a hospital staff. There would be practice guidelines that would be developed with respect to particular procedures. Those practice guidelines would be adopted by a hospital staff.

Mr. WALGREN. So your point is that the national expenditure target is really designed to impact on practice guidelines, not directly on individual physician behavior.

Mr. LEE. Practice guidelines and utilization review processes, so that the best knowledge we have would be used much more effectively in the utilization review and physicians would be activated and would be participating in those processes much more than they are today. It is not an incentive designed to affect individual physicians. It is not saying to an individual physician, "Your volume has to be" such and such. It is going to be peer judgments about practice. It would, we hope, improve the quality of care by diminishing the amount of inappropriate service provided. It is that kind of broad incentive.

The second thing it does is provide insurance when you are reforming payment and you can't predict in advance what effect that will have in volume. This way, the Congress can assure that spending will be kept within reasonable bounds.

Mr. WALGREN. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Bruce.

Mr. BRUCE. No questions at this time, Mr. Chairman.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Just one question. I think my colleague, Congressman Walgren, makes a very important point with respect to the relationship of the practice guidelines and the expenditure targets, because if, say, expenditure targets go in right away and practice guidelines take 2 or 3 years to put in, it seems to me you have got real problems on your hands as it relates to what you really want to do.

Is it your view, Dr. Lee, that you should not have expenditure targets kick in before the practice guidelines are in place?

Mr. LEE. The expenditure targets, we think, should go into effect when the Medicare fee schedule goes into effect. We believe at that time you will have sufficient information. There is, we believe, a wealth of information available now that can be drawn on and that we could move very quickly in this direction. We would not delay the implementation of those expenditure targets. We would set the targets at very close—I mean you can finetune targets.

If you set the targets close to what you project volume increases to be, you are not going to have a dramatic effect at the outset. In other words, there would be a gradual transition. If you expect volume to increase 7 percent, practice costs to go up 4 percent, and elderly to go up 2 percent, you have got a 13 percent increase. Let's say you have set your target the first year at 12 percent, a 12 percent increase instead of a 13 percent increase. We think that is very feasible to achieve that. Yet, in the out years, even those very slight reductions in volume achieve very substantial savings downstream.

Mr. WYDEN. I guess what I would say on that point is, it sounds a little bit like wishful thinking. I just think that unless you have those practice guidelines in line with the expenditure targets, I think you are not making these two parts work in tandem. You know I admire the work you have done and appreciate the way you have reached out to Members of Congress, but that would be another point.

Mr. LEE. Let me just say a word about the targets. If you don't have expenditure targets as an incentive, you are not going to have physicians moving as rapidly as they can move and should move to deal with practice guidelines. We think it provides an incentive. You can monitor that very, very carefully year to year to make sure that you don't, you might say, overkill in that arena.

Mr. WYDEN. I asked for one question, Mr. Chairman. Thank you.

Mr. WAXMAN. I want to explore that last statement. Your view is that unless you have expenditure targets they won't proceed to practice guidelines. Why would you believe that to be the case?

Mr. LEE. I think the expenditure target provides a major incentive to deal with the volume problem. We have had very little effective work done to deal with the volume problem. There are a significant amount of inappropriate services provided currently. We are not seeing now sufficient action on the part of—whether it is the College of Surgeons, the College of Physicians, have worked to develop——

Mr. WAXMAN. Let me interrupt you.

Mr. LEE. Yes.

Mr. WAXMAN. Who is going to enforce this? You set up a practice pattern. Do you expect each specialty to enforce it within the specialty, and if they have doctors who are not following those practice patterns, are you going to cut doctors who are practicing the patterns?

Mr. LEE. The payment, of course, is made by the carrier. If they are within the practice expenditure targets, everything is fine. If, at a local level, you establish practice guidelines, let's say at a community hospital, if there are physicians who do not practice within those practice guidelines and the community of physicians says this is the norm, then there are a variety of actions that can be taken, particularly at the hospital staff level.

Mr. WAXMAN. Wouldn't this, under Medicare, result in a reimbursement reduction for all physicians in a grouping because some are not following the practice pattern?

Mr. LEE. My own view is that the Congress should establish the national target. The Secretary should have the discretion to decide whether that should be done geographically or, as the College of Surgeons has suggested, they have suggested, do it by specialty, take all the surgical specialties and include them in an expenditure target for surgery.

I think that over time those different systems can be worked out. The Commission has been very much in favor of a national target, of having the entire profession involved, not separating out surgeons and others, but those are things that could be looked at by the Congress or by the Secretary as modifications of the proposal that we have made.

Mr. WAXMAN. Under your proposal where you take the whole profession, and you put a target objective, if that target objective is not met, the consequences, as I understand it, are reductions in the reimbursement levels for all——

Mr. LEE. There would be the reduction in the increase. In other words, each year there is an increase in payment.

Mr. WAXMAN. It would be applied to everyone equally——

Mr. LEE. Correct.

Mr. WAXMAN [continuing]. Whether they are violating the practice patterns, as you would see it, or they are trying to be prudent and trying to live up to the norms and hold down their volume.

Mr. LEE. The utilization review process both through the carriers and the PRO reviews is a second mechanism, and we think there should be much more physician involvement in both of those processes to improve those behavior patterns, so that if you find outlier physicians, there are ways to discipline them economically at that point without then affecting all the physicians.

I mean if you find physicians who are deviating from those practice guidelines, you deal with that through your utilization review mechanisms either with preadmission screens or with your concurrent review or with your PRO review, so that you deal with those, you might say the outliers, in that process rather than penalizing all the physicians in terms of their payment increase in subsequent years.

Mr. WYDEN. May I ask just one other, Mr. Chairman?

Do all the savings come from setting the expenditure targets, Dr. Lee? We were talking about the $4 billion.

Mr. LEE. That $4 billion is our estimate if the expenditure target was set at 2 percent below the CBO increases that have been estimated for 1994.

We think that there will be some savings, but it is very difficult to estimate those by more rational payments. It is just impossible to give you an accurate projection of what those savings might be.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Walgren.

Mr. WALGREN. Thank you, Mr. Chairman.

Somehow or other, it seems to me that either you build the system from the practice guidelines up or you build it from an amount that you are going to cap down, and what I hear you saying is that you want to put maximum pressure on the creation of these practice guidelines, the development of those guidelines, in the most restrictive sense, and that is why you are reaching for the cap. Am I right?

Mr. LEE. There are two reasons for the cap. The fundamental reason for the cap was the Commission's consensus—and there was consensus—that we cannot afford as a country to continue to put the amount of money into part B of Medicare that we are putting in every year, the increasing amounts of money; the country can't afford it if we are going to do anything else in the health care area, particularly the uninsured Medicaid, those arenas. That was the fundamental reason.

As a secondary benefit of the expenditure target, it would have these benefits, we believe, with respect to practice guidelines.

Mr. WALGREN. Now let me understand that. When you say we cannot afford to pay more, are you talking about more pure dollars or more as a percent of GNP? This apparently is the operating assumption.

Mr. LEE. The expenditure cap comes from the increasing percentage, the increasing dollars and the increasing percentage of GNP, going to part B. It is, as I understand it, the most rapidly increasing part of the Federal budget.

Mr. WALGREN. So it is the increase in the percentage you are talking about.

Mr. LEE. Correct.

Mr. WALGREN. Because you could pick any number out of the air and say we don't want to pay more than that, and that is just your view and no one else's, I would gather.

Mr. LEE. It is the rate of increase.

Mr. WALGREN. So the starting assumption was that there should be no more increase in the percentage of social effort given to physicians' fees.

Mr. LEE. We didn't have a percentage. We didn't set a total percentage. We just said that the rate of increase cannot be sustained if Congress is going to meet these other needs.

Mr. WALGREN. So the assumption was, it should be less than present.

Mr. LEE. The rate of increase should be less. That was the main assumption.

Mr. WALGREN. Mr. Chairman, if I might, one other thought.

When you set a cap and you exceed the cap, I gather then, to put maximum pressure on the development of these practice guidelines, which is what I hear you saying we should do, you would then recover the overexpenditure of last year by reducing not just to what you want it to be this year but then actually reducing that further to recover the amount that you overshot last year, so that from a physician's standpoint, he or she would not only find this year's reimbursement set at a lower rate but then there would be a reduction of that to recover from last year's differential. That is the way you put the maximum pressure on practice guidelines. Is that right?

Mr. LEE. What we are recommending be done is, with your practice cost increase from year to year, what is now the MEI—and, of course, Congress is already doing this now; you already have an expenditure cap. You do it after the fact, you do it without an explicit goal, and you do it with respect to budget reductions, but there is an expenditure cap now in part B of Medicare.

We would propose it be made explicit that that fee increase from year to year that comes from the practice cost increase, your MEI increase, that rate of increase would be reduced sufficient to recapture the money that you overspent the previous year.

Mr. WALGREN. So you would not only, as I understand it, limit it to a limited medical index, MEI——

Mr. LEE. Right.

Mr. WALGREN [continuing]. But then you would also ratchet that down for the succeeding year to recover what might have been overshot the previous year.

Mr. LEE. You would do that recovery that subsequent year, but you would continue your MEI update. You would calculate the MEI update based on actual practice costs for the subsequent year. In other words, the MEI or the practice cost update is based on the actual costs of practice. If there is a high inflation year, it is higher. If there is a low inflation year, it is lower.

Mr. WALGREN. Thank you, Mr. Chairman.

Mr. WAXMAN. If you looked down the road and you had practice guidelines worked out and in place, would you want the system to

try to control those who are beyond the practice guidelines, or would you still want this overall target with the broad reductions for everybody involved?

Mr. LEE. I think there are some physicians who are outliers, who are constantly doing things that are beyond the norm. Once you have developed those parameters, there are physicians who occasionally do things outside the norm, and that you would look at both in terms of your local hospital utilization, but you would also look at that through utilization review with the carriers and with your PRO reviews.

Mr. WAXMAN. At that point, would you want to eliminate this overall cap if you have a more refined way to deal with those who are going beyond the norm in terms of volume?

Mr. LEE. If you have a more effective way to do it and if the expenditure or the rate of increase of expenditures is controlled, there might be some day when you wouldn't need an expenditure target, but my own view is that in the foreseeable future—let's say for at least for the next 5 to 7 years—that is a sound policy to adopt. If we find significant better ways to control the volume and make volume appropriate, if we just did what was appropriate, we would save 20 percent in the cost of medical care. Then you wouldn't have to worry about an expenditure target at all, if we were in fact at that place.

Mr. WAXMAN. But in order to eliminate those kinds of services that are inappropriate, you are going to cut the fees for those who are providing services that you would consider appropriate.

Mr. LEE. That is correct, but the main focus would be, through this utilization review mechanism, to deal with those to try to cut that off.

Mr. WAXMAN. But you could have that without an expenditure target.

Mr. LEE. You could have that, but it is not working as well, and we think the expenditure target is going to juice up that process and make it more effective, and particularly mobilizing physicians to much more actively develop the practice guidelines and apply those, disseminate them, and also, very importantly, the effectiveness research, which is one of our other recommendations, is a very important component of all this. Downstream that is going to be as important as anything you do this year, to enact legislation that really moves that forward.

Mr. WAXMAN. I understand what you are saying, and I thank you very much.

I think we have completed the questioning, and we very much appreciate your presentation.

Mr. LEE. Thanks, Mr. Chairman.

Mr. WAXMAN. We would like to now call forward the following individuals to testify in a panel: Dr. John J. Ring, chairman of the board of directors, American Medical Association; Dr. Edwin P. Maynard, president of the American College of Physicians, who will be accompanied by Deborah, Prout, director of public policy, American College of Physicians; and Dr. Robert Graham, executive vice president, American Academy of Family Physicians.

We are pleased to welcome you to our subcommittee hearing. Your prepared statements will be made part of the record in full.

We would, however, ask you to limit your oral presentation to no more than 5 minutes.

Why don't we start with Dr. Ring.

STATEMENTS OF JOHN J. RING, CHAIRMAN, BOARD OF DIRECTORS, AMERICAN MEDICAL ASSOCIATION; EDWIN P. MAYNARD, PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS; AND ROBERT GRAHAM, EXECUTIVE VICE PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Mr. RING. Thank you, Mr. Chairman.

My name is John J. Ring. I practice family medicine in Mundelein, IL. I am the chairman of the board of the American Medical Association. With me today is Bruce Blehart of AMA's Department of Federal Legislation.

The AMA strongly supports a rational review of physician reimbursement. In our view, an indemnity payment system utilizing an RBRVS has the best potential for setting future physician reimbursement directions. The RBRVS study is now being expanded, corrected, and refined by Harvard, and at this point we believe that when it is it would provide an acceptable basis for a Medicare indemnity payment system.

Mr. Chairman, as you have heard, the PPRC has recommended that legislation be enacted this year to implement the RBRVS. However, there are many issues that first need to be addressed.

As previously noted, the researchers at Harvard are presently in the process of expanding, correcting, and refining their initial study, and their revised study should be completed next spring. In addition, the report required by Congress on this matter from the Secretary of HHS is due by July of this year.

The just released HCFA data on geographic impact of RBRVS enactment are specifically labeled as preliminary estimates. More research needs to be focused on the geographic cost index and the effects on access-related adjustments to this index. Also, implementation of an RBRVS will require a detailed reexamination of geographic areas for payment purposes. The impact of the RBRVS on access to care is essential.

With the hindsight of how the DRG payment methodology has worked for part A of Medicare, it should be apparent that RBRVS legislation should not be enacted in a precipitous fashion. With that said, I can tell you that the AMA is quite optimistic that legislation to initiate a transition to a new Medicare payment schedule could be appropriately considered after the resolutions of the issues I have discussed.

We are also concerned over the proposal of PPRC of tying implementation of RBRVS to Medicare expenditure targets which we think would imply the creation of an implicit system of rationing health care. Rather than ration care, efforts to improve quality and outcome assessment to eliminate unnecessary or inappropriate services should be accelerated. The AMA has already started this process. We are in the process of developing practice parameters for appropriate care. Medicine does not require punitive expenditure targets to act effectively and responsibly to reduce inappropriate care.

Finally, the AMA supports continuing the policy of allowing Medicare assignment decisions to be made on an individual basis. We support PPRC's decision not to recommend mandated assignment under the Medicare program.

The AMA encourages physicians to take their patients' economic status into account, and the facts say that we do just that. Assignment is at an all time high, and over 40 percent of physicians, including the one you are looking at right now, are participating physicians.

In conclusion, health care in this Nation is approaching a crossroads, and the choice of which road will be pursued will fashion our health care system well into the 21st century. We urge caution so that the decisions you make now do not take us down the wrong road, a road where Americans have to line up and wait for essential health care, as seen in some provinces in Canada right now, or a road that denied services to citizens based on age, as is now seen in Great Britain.

The choices you face are important ones, and we urge you to follow the directions that will assure our continued ability to care for our Nation's elderly and disabled.

Thank you, Mr. Chairman. I will be pleased to respond to questions when the time comes.

[Testimony resumes on p. 81.]

[The prepared statement of Mr. Ring follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives

Presented by

John J. Ring, M.D.

RE: Medicare Part B and the Fiscal Year 1990 Budget

May 25, 1989

Mr. Chairman and Members of the Subcommittee:

My name is John J. Ring, MD. I am a physician in the practice of family medicine in Mundelein, Illinois and I am the Chairman of the Board of Trustees of the American Medical Association. With me today is Bruce Blehart of the AMA's Department of Federal Legislation. The AMA appreciates this opportunity to participate in the Committee's hearing concerning proposals to cut up to $2.3 billion from the projected Medicare budget for fiscal year 1990.

As a starting point, we want to express our gratitude that the Congress already has seen fit to pare substantially the over $5 billion in Medicare cuts proposed by the Administration. While this action recognizes that the Medicare program already has been subjected to over a decade of major cuts, we are strongly concerned that further cuts will jeopardize our ability to provide necessary services to our elderly and disabled patients.

MEDICARE PROGRAM CUTS

The American Medical Association believes that it is time to stop trying to balance the budget on the back of the Medicare program. Nevertheless, we do appreciate the dilemma you are facing. We understand the compelling need to find substantial savings in a federal budget when the deficit is so immense that interest on the national debt is now the third largest component of the overall federal budget. On the other hand, further cuts in the Medicare program -- the guarantor of health care coverage for over 33 million Americans -- will impair our ability as physicians and as a society to continue to meet the promises of this program. In your deliberations, we urge you to apply an evenhanded approach. Absent a determination to apply an across the board approach to freeze all federal spending, the AMA cannot endorse further cuts being made in the Medicare program.

The Medicare program, and Part B of Medicare in particular, have borne a disproportionate share of federal budget cuts:

> Medicare Cuts vs. Total Federal Budget-Cuts - From 1980 to 1988, actual Medicare spending compared with Office of Management and Budget (OMB) projected current services spending shows that $7.9 billion was cut. During this same period, and notwithstanding this sharp reduction in Medicare expenditures, total federal spending actually increased by $120.3 billion over OMB projected current services spending.
>
> Proportionality of Medicare Cuts - According to a 1988 GAO report that examined the impact of reconciliation actions through 1986, both Part A and Part B were cut substantially during the 1980s. The sum of the budget savings estimated by HCFA through the 1986 Omnibus Budget Reconciliation Act is approximately $18.2 billion for Part A and $13.4 billion for Part B. This represents a 6.9% reduction in cumulative Part A outlays and a 10.9% reduction in cumulative Part B outlays. Relative to the respective program sizes, Part B was cut about one and one-half times more than Part A.

We challenge and want to dispense with the mistaken impression that physicians have been relatively untouched by past budget cutting actions. Our experience is contrary and the facts are incontrovertible:

- Medicare reimbursement and fees were frozen for most physicians for 40 months from July 1983 to 1987;
- Medicare reimbursements for selected procedures were cut across-the-board by a total of 12% in 1987 and 1988, and special limits were imposed on physician fees for these procedures;
- The Medicare allowed amount for an office visit is only 73% of the amount actually billed by physicians to other patients (according to our 1986 survey); and
- Physicians presently are the only profession subject to federal price controls, the maximum allowable actual charge program.

(A summary of recent actions limiting physician reimbursement and charges is attached as Appendix I.)

Mr. Chairman, we will not try to delude you or the Committee by denying that some savings cannot be found in an $89 billion program where approximately $24 billion was spent for physician services and $49 billion was spent for inpatient hospital care in 1988. However, cuts in a people oriented program such as Medicare cannot be achieved without commensurate pain, and it is wholly unreasonable to expect that Part B, the component of Medicare dedicated to assuring access to physician care, should bear the brunt of any new program reductions. In this regard, we fully share the view you so eloquently made earlier this month before the House of Representatives:

> ... When you limit DRG payments or reduce physician fees so they lag behind private payment rates, this has a serious

> effect. Eventually, it reduces the quality and quantity of care. Medicare beneficiaries know they are being pushed out of hospitals more quickly; they know their access to physicians is suffering. Medicare payments cannot lag behind inflation year after year without resulting in a deterioration of our health care system.
>
> Many Members of this House have indicated concern that years of Medicare DRG limits have put many hospitals in a precarious financial state, and are affecting quality of care particularly in rural and large urban hospitals. I am sympathetic to that. But Part B of the Medicare Program cannot absorb the bulk of these cuts without equally serious impacts on quality of care. If we keep paying physicians less than private payors do who can believe that our Medicare population will not be shortchanged. Access will be harder. Visits will be shorter. Quality will be affected. If we are compelled to make Part B absorb $1 billion of these cuts, we will have to put a total freeze on physician payments. We cannot do more. We cannot responsibly do that. So our choices will not be happy ones. And our constituents who depend on Medicare will be the losers.

With the impact of massive legislative changes from past budget directed actions not even fully known, we strongly caution against further program changes that are aimed at achieving dollar savings as opposed to rational program improvement. Program changes, especially those imposed in the name of dollar savings, carry a real impact on our patients. If there is to be no across the board measure, and if Congress decides that Medicare spending cuts are unavoidable, we believe that any reductions Between Part A and Part B of Medicare should be done in proportion to actual outlays.

REIMBURSEMENT CUTS FOR "OVER-PRICED" SERVICES

The AMA is very concerned that the perceived need to find budget savings will result in further cuts in reimbursement for selected services that have been identified by some as "over-priced." The Administration's fiscal year 1990 budget recommendations call for further reimbursement cuts of up to 12% for services which have already been subjected to considerable cuts.

[The Omnibus Budget Reconciliation Act of 1987 required reductions in the prevailing charge levels for cataract surgery, coronary artery bypass surgery, total hip replacement, transurethral resection of the prostate, suprapubic prostatectomy, diagnostic and/or therapeutic dilation and curettage, bronchoscopy, knee arthroscopy, knee arthroplasty, pacemaker implantation, upper gastrointestinal endoscopy, and carpal tunnel repair. After an initial 2% cut in prevailing charge levels for these services was applied in 1988, prevailing charge levels for these procedures were further reduced (where they were above 85% of the weighted national average) in 1989 by up to 15% based on a sliding scale.]

The AMA is very concerned that further immediate cuts in reimbursement for these services could work substantial hardships on those who could benefit from such care. Even before the specific cuts aimed at these services were imposed, access to care by Medicare beneficiaries was being reduced.

The results of a 1987 survey into how physicians have changed their practice patterns as a result of Medicare program changes imposed since 1984 revealed that 22% of the physicians who regularly treat Medicare beneficiaries had taken measures that result in restricted access to care for their Medicare patients. According to this survey, physicians have reduced the number of or did not accept new Medicare patients; and/or have reduced the number of or did not perform certain procedures for Medicare covered patients.

Without any analysis having been conducted on the effect of the last round of cuts for these services, we are particularly concerned over the effect of even further and substantial reimbursement cuts. The AMA does not believe that arbitrary statutory reductions are the appropriate means to address the larger issue of physician reimbursement under Medicare.

PHYSICIAN PAYMENT REFORM

There is little dispute that the Medicare methodology for setting physician payment and reimbursement levels is overly complex and often creates inequitable results. The fact that current physician reimbursement and payment levels are based on 1971 actual charges as

their starting point and have been subjected over the years to a myriad of payment and fee controls illustrates why the system is fraught with inequities.

The AMA strongly supports a rational review of physician reimbursement, as has been conducted recently by a research team at the Harvard University School of Public Health, which recently released its resource-based relative value scale (RBRVS). In our view, an indemnity payment system utilizing an RBRVS has the best potential for setting future physician reimbursement directions. The AMA believes that such a payment system could ameliorate many of the uncertainties inherent in current Medicare payments and also ameliorate inequities. It also would provide patients with a greater understanding of the financial obligations for each service. The RBRVS study now is being expanded, corrected and refined by Harvard, and it is being analyzed by the Department of Health and Human Services (which by law must issue its own RBRVS report by July of this year), the Physician Payment Review Commission (PPRC), the AMA and others.

At this point, we believe that the current Harvard study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system. The AMA has identified seven specific areas of the Harvard study that need additional work prior to its use in Medicare payment determinations:

- Restudy of specialties whose RBRVS data have significant, documented technical deficiencies;
- Fundamental improvement of the measurement of relative practice costs and specialty training costs;
- Expansion of the RBRVS to more specialties and services;
- Development of an extrapolation method for visits;

- Revision, refinement, and expansion of pre- and post-service work measurement;
- Expansion and validation of the current extrapolation method; and
- Development of relative value estimates for global surgical services as standard definitions are developed and accepted.

Much of the work necessary to complete and improve the RBRVS is underway in the study's second phase, as well as in the efforts of the PPRC and others to refine the treatment of practice costs and other factors. As a study subcontractor, the AMA is participating actively with Harvard and a number of specialty societies in the process of expansion and refinement needed to produce a technically adequate RBRVS.

RBRVS Implementation

Mr. Chairman, as you know, the PPRC has recommended that legislation be enacted this year to implement the RBRVS as part of the impending reconciliation process. Indeed, we do not doubt that you have heard or will hear from individual physicians who will urge you to accept this PPRC recommendation. However, there are many issues that need to be addressed.

As previously noted, the researchers at Harvard University are presently in the process of expanding, correcting and refining the initial study, and their revised study should be completed next spring. In addition, the report required by Congress on this matter from the Secretary of HHS is due by July of this year.

Another matter that needs to be addressed is that physicians who would have to understand and live with the new system are unprepared for the significant changes a new payment system would impose. With physicians presently reeling from Medicare demands, we are very concerned over how imposition of a new payment system in 1990 would be received.

Data from a recently published survey of Texas physicians on their knowledge of the RBRVS indicate that: 15% knew "nothing at all;" 32% knew "not much;" 45% knew "some;" and 8% knew a "great deal" about the RBRVS. The bottom line is that, in spite of all of our activities to educate physicians about the RBRVS, more needs to be done prior to implementation.

Recently released data from HCFA also points to why implementation of the RBRVS at this time needs careful study. From their analysis of about half of the charges for physician services from the 1987 procedure file, HCFA has released estimates of the geographic impact of a budget neutral RBRVS implementation. As demonstrated in the attached charts (Charts 1, 2 and 3) showing gains and losses from select states, what one would have thought to be the expected outcome has not been projected. States which common sense says are rural and that should stand to gain under an RBRVS implementation are among the largest potential losers (Kansas, New Mexico and Texas), and even a rural carrier area like Lubbock, Texas is listed as having a nineteen percent (-19%) loss. These results demand greater investigation as to the impact of such shifts in resources between states and localities and on access to care.

Further investigation of the geographic impact of RBRVS enactment is essential. The HCFA data is specifically labeled as "preliminary estimates," and more research needs to be focused on the geographic cost index (the HCFA geographic data is based on 1980 cost data). The HCFA data also gives credence to the AMA position that implementation of an RBRVS will require a reexamination of geographic areas for payment purposes.

With a program change of the magnitude of totally changing how over $24,000,000,000 in payments will be determined for over 350,000 physicians for over 350,000,000 claims for services provided for more than 24,000,000 people we believe that extensive hearings and discussions are essential. With the hindsight of how the DRG payment methodology has worked and currently is working for Part A of Medicare, it should be apparent that RBRVS legislation should not be enacted in a precipitous fashion.

Based on what we know about the ongoing efforts of Harvard and the PPRC to produce an acceptable RBRVS, the AMA is quite optimistic that legislation to initiate a transition to a new Medicare payment schedule (based on the resource cost of providing physician services) could be appropriately considered after resolution of the issues discussed above and completion of Harvard's activities. We look forward to working with the Committee toward that end.

EXPENDITURE TARGETS

The PPRC's recommendation calling for Medicare expenditure targets constitutes a radical departure from our nation's commitment in creating the Medicare program to provide the elderly with all necessary medical and other acute health care. It will replace that commitment with a system of economic incentives to withhold services to meet the expenditure target. In effect, it calls upon physicians to make the rationing decisions for society on a case-by-case, encounter-by-encounter basis.

The PPRC recommendation may appear to be a painless way to hold the line on program expenditures, but the bottom line of a decision to impose expenditure targets is the creation of an implicit system to ration health care. A national target that is tied arbitrarily to a formula based heavily on a political judgement about the appropriate rate of increase in

volume of services per enrollee, rather than medical judgement about actual health care needs, provides the starkest possible proof of this point.

In addition to our view that rationing is not an acceptable direction to reduce Medicare expenditures, the American people do not want rationing of health care for the elderly and disabled. Public opinion surveys consistently find that the American people want to cover the health care needs of these populations:

- In response to a 1986 poll conducted for NBC News and the Wall Street Journal, when asked: "To help reduce the federal budget deficit, would you favor reduced benefits for Medicare or not?... 86% answered that they opposed reduced Medicare spending.

- In response to a 1987 poll conducted for ABC News and the Washington Post, when asked: "Should spending for (the Medicare program which helps reduce health care costs for the elderly) be increased, decreased or left about the same?"...only 3% called for decreased spending, 22% called for spending to stay the same, and 74% called for increased spending.

- In response to a 1988 poll conducted for NBC News/Wall Street Journal, when asked: "Do you want to see the federal government spend more or less money ...to provide health care for the elderly?"...only 5% called for less spending, and 83% called for more spending to meet the health care needs of the elderly.

Expenditure Target Experience

Establishing a nationwide or regional system of expenditure targets eventually would devolve into a system that would mirror many of the same problems evidenced in those Canadian provinces (British Columbia, Alberta and Quebec) that limit total expenditures for medical and health services. With their experience as a model as to what could happen in our country, there is mounting evidence that limiting program benefits through expenditure targets will result in medically unacceptable results.

As recently reported in the Canadian press, their health system is starting to deteriorate and rationing is now being openly discussed. According to the Canadian weekly newsmagazine Maclean's (February 13, 1989) patients have died after long waits for needed surgery. Other examples from these provinces that maintain an expenditure target system present a telling story:

- The wait in Vancouver for psychiatric, neurosurgical or routine orthopedic consultation is 1 - 3 months, 6 - 9 months for cataract extraction, 2 - 4 years for corneal transplantation, and 6 - 18 months for admission to a long term placement bed.
- Many waiting lists in the province of Quebec for angiograms are six months long.
- The wait in the province of Quebec for coronary artery bypass surgery is 8 - 9 months.
- Montreal and Vancouver emergency departments often have no capacity to handle new patients.
- In all of Canada, there are only 11 hospitals that are capable of performing open heart surgery (793 in the U.S.), 14 hospitals capable of performing organ transplants (319 in the U.S.), and only 12 hospitals have magnetic resonance imaging (MRI) equipment (there are no MRI facilities outside of hospitals in Canada). [Canadian figures are from 1988 and U.S. figures are from 1987.]

Based on this directly relevant Canadian experience, Congress not should experiment on our elderly population with this type of proposal. Such a system is unprecedented in the United States and holds very real risks for our elderly and disabled patients.

Improving Quality and Outcome Assessment

Rather than ration care, efforts to improve quality and outcome assessment to eliminate unnecessary or inappropriate services should be accelerated. This goal can best be achieved through funding of research into quality assessment so that clinically sound guidance can be provided

to physicians for integration into their practices. The AMA supports the PPRC recommendation for increased funding in this area.

The Association believes that one potential and workable solution to help assure the provision of high quality care is the development of practice parameters. The AMA strongly supports the development of clinically relevant parameters that are designed to assure that patients receive appropriate medical care. Through the AMA Office of Quality Assurance and Assessment, the AMA is taking a lead role in clinical appropriateness initiatives. Medicine does not require punitive expenditure targets to act effectively and responsibly to reduce inappropriate care.

MANDATED ASSIGNMENT

The AMA supports the PPRC's current decision not to recommend mandated assignment under the Medicare program. As you well know, mandated assignment would require physicians to accept the Medicare allowed amount as payment in full regardless of the excellence or unique nature of the services provided or the ability of the patient to pay the physician's regular charge for the service.

Medicare already substantially discounts physicians' fees. The gap between Medicare allowed amounts and physicians' regular fees has grown from 10% in 1970 to the current approximate level of 27% (office visit). In other words, years of budget cuts and regulation have left Medicare paying only 73% of physicians' regular fees.

In any discussion of mandatory assignment, it must be realized that the total a physician may bill a patient between the allowed amount and the maximum allowable actual charge represents only a small percentage of the total out-of-pocket expenses a Medicare beneficiary may experience.

HCFA estimates average out-of-pocket costs were about $600 in 1987 per aged beneficiary for Part B services. Of that total, balance billing amounts accounted for about only 18%, while co-insurance amounts accounted for approximately 32%, deductibles accounted for approximately 12%, and premiums accounted for approximately 38% of patient financial liability. (See attached Chart 4.)

It is also important to note that physician balance billing and other beneficiary expense responsibilities do not represent a financial barrier to needed care. The data from the PPRC's beneficiary survey report that only 6.4% of respondents did not seek care during the previous year because of the cost, with only 3.1% putting off treatment for a serious condition. Only 0.2% reported being actually denied care for financial reasons (including deductible, co-insurance and balance billing). Although any delay in seeking treatment due to financial considerations is worrisome, these numbers do not suggest that balance bills exert a negative impact on access.

This record clearly demonstrates that physicians do care about their patients' economic circumstances and accept assignment a vast majority of the time. Physician acceptance of assignment has continued to increase to all-time record highs. The fact that assignment is at an all time high, with 79.3% of charges being assigned in the last quarter of 1988 and with new data indicating that 40.7% of physicians are participating in 1989 (an increase of 9.1%), demonstrates the reality that physicians are responsive to their patients' situations. The AMA encourages physicians to take their patients' economic status into account and data show that they do. An Urban Institute study summarized evidence that

physicians are more likely to assign claims in low-income areas. The Physician Payment Review Commission's physician survey revealed that patients over age 75 were more likely to have claims assigned, and that claims are more likely to be assigned if the patient lacked supplementary insurance. Another PPRC analysis found that voluntary assignment rates were higher for poor patients than for better-off ones. Consider the following points from the PPRC surveys:

- For individuals with a regular source of care, the PPRC beneficiary survey reported that the voluntary assignment rate (excluding Medicaid) from the patient's regular physician was 56%, and 68% on the last visit with a specialist. The physician survey found that of non-participating physicians, 85% routinely accepted assignment for some of their patients, regardless of the service provided, and that 95% of these physicians consider the patient's financial status in this decision.

- When beneficiaries were asked whether they were actually balance billed on their most recent bill, only 17% indicated that they had been, with those over age 85 and those below 200% of the poverty level least likely to have received such a bill.

- A PPRC analysis of 1987 data from eight states found that 3% of patients had annual balance bills exceeding $500, that 52% had no balance billing liability and 30% had balance bills of $50 or less. Even among those patients with more than $5,000 in annual Medicare allowed charges, the majority had $50 or less in balance bills.

Policy approaches that restrict or eliminate physicians' ability to establish their fees are not warranted. When one studies the distribution of balance bills and the actual amount of individual bills, as the PPRC has, it becomes clear that there simply is not a large enough number of persons who are experiencing substantial financial problems from balance bills to justify mandating assignment or imposing stringent charge restrictions for all Medicare beneficiaries.

With a Medicare fee schedule, the problems of mandatory assignment would be compounded because no fee schedule can adequately reflect differences in practice costs, patient severity, quality, amenities and other factors. Without the ability to balance bill, there will be no recognition of experience or other special abilities. The remuneration for a physician on his or her first day of practice for a service will be the same as for a highly skilled practitioner with decades of practice experience.

For many of the same reasons, we oppose the Commission's recommendation to control physicians fees through what would amount to a new set of Maximum Actual Allowable Charges. Controls on physician fees should not be imposed while the rest of the economy is unregulated. Such fee controls encourage patient demand and increased utilization by keeping the price of medical services artificially low. Such controls also fail to reflect increases in the costs of goods and services in the uncontrolled market that physicians must pay. Price controls will distort the payment system in a manner similar to mandatory assignment. We believe that the MAAC program should really be allowed to terminate as Congress intended.

It also must be realized that limits on balance bills will pose a financial risk to the Medicare program. Studies on the effects of cost-sharing by the Rand Corporation and the Congressional Budget Office indicate that elimination of balance billing would cause an escalation in patient demand and could greatly increase Medicare expenditures.

Finally, let me expand on the AMA's efforts in encouraging physicians to consider their patients economic status in the assignment decision.

There are currently 34 state medical society voluntary assignment programs either underway or in development. Additionally, there are numerous county programs in effect, many in areas without state programs.

CONCLUSION

Mr. Chairman, health care in this nation is approaching a crossroads and the choice of which road we pursue will fashion our health care system for the American people into the 21st century. We urge caution so that the decisions you make now do not take us down the wrong road -- a road where Americans have to line up and wait for essential care as seen in the expenditure target provinces of Canada, or a road that denies services to citizens based on age as seen in Great Britain. While this point may seem too far off to be of concern, remember that those patients who today have limited access to care in Canada and Great Britain did not have a chance to express their views when action to limit total program payments were initiated years ago.

The choices you face are important ones, and we urge you to follow the directions that will assure our continued ability to care for our nation's elderly and disabled.

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APPENDIX I

Physician Reimbursement Restraints Under Medicare

Since the inception of Medicare, Congress and the Department of Health and Human Services have taken actions that have resulted in reductions in Medicare reimbursement for services provided by physicians for Medicare beneficiaries. The result of these actions has been that physician reimbursement under Medicare consistently has been compressed to a point where the maximum Medicare reimbursement rate, the "prevailing charge," usually does not reflect the actual prevailing charge for these services.

In 1969, prevailing charge levels were lowered from the 90th percentile to the 83rd percentile of customary charges. In 1970, prevailing charge levels were lowered to the 75th percentile of customary charges. For the second half of the 1971 fiscal year, physician's customary charges were based on the physician's median charge during the 1969 calendar year.

In August 1971, nationwide wage and price controls were imposed. While these controls were lifted seventeen months later for most of the economy, they still were retained for physicians for an additional fifteen months -- until May 1974.

In 1972, Congress established further restraints through use of an economic index as a means to limit the rate of annual increase in prevailing charge levels. In 1976, the Medicare Economic Index (MEI) as used to set the prevailing charge limits using fiscal year 1973 charge screens that were based on physicians' charges during calendar year 1971.

Starting with the Deficit Reduction Act of 1984 (DRA) further and substantial limits were imposed on physician reimbursement and charges for services provided Medicare beneficiaries. The DRA modified physician reimbursement in the following ways:

Two classes of physicians were created: "participating" physicians who agreed to accept all Medicare claims on an assigned basis and "non-participating" physicians who may continue to accept assignment on a claim-by-claim basis;

Medicare maximum reimbursement levels for physician services, customary and prevailing charge levels, were frozen for the period of June 30, 1984 to September 30, 1985 (if no freeze had been imposed by the DRA, the economic index would have allowed a 3.34% increase of prevailing charge levels on July 1, 1984);

The scheduled July 1, 1984 increase in fee profiles was eliminated, and the future annual update in fee profiles was delayed from July 1 to October 1, with the next increase set for October 1, 1985; and

Fees for services provided Medicare beneficiaries by "non-participating physicians" were frozen during this 15-month period. (Participating physicians were allowed to increase their fees for Medicare beneficiaries, but they are not allowed to collect this increased fee because of the agreement to accept assignment on all Medicare claims.)

The Emergency Extension Act again froze physician payment levels at the rates in effect on September 30, 1985 for 45-days. (This Act prevented a 3.15% increase from being applied to Medicare prevailing charge levels on October 1, 1985.) This Act also rolled back the actual charge levels allowed physicians who "participated" in FY85 but who had not agreed to "participate" in FY86. Further legislation extended the Extension Act, with fee and reimbursement levels again frozen through March 15, 1986.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) yet again extended the Medicare reimbursement freeze: i) the freeze on Medicare reimbursement and charges for non-participating physicians was continued through December 31, 1986; and ii) the freeze in the customary and prevailing charge levels for participating physicians was allowed to end May 1, 1986, with the prevailing charge increase for participating physicians set at only 4.15%.

The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) made substantial modifications in physician reimbursement and fee limits.

Reimbursement - Both participating and non-participating physicians were allowed an equal 3.2% update in Medicare prevailing charge levels beginning January 1, 1987. Beginning on January 1, 1987, prevailing charges for non-participating physicians were set at 96% of the prevailing charge levels allowed participating physicians.

Fees - The freeze on actual charges of non-participating physicians expired on December 31, 1986 and was replaced by Maximum Allowable Actual Charge (MAAC) limits. Each MAAC is determined by a complicated formula applicable to every charge of every individual physician. Physicians are subject to substantial penalties for violation of MAAC limits. MAAC limits are determined as follows:

If the physician's actual charge for any given service is at or above 115% of the prevailing charge (as determined from year to year), the actual charge for that service may be increased by no more than 1%. If the actual charge is less than 115% of the prevailing charge, that charge may be increased by the greater of 1% or as follows:

January 1, 1987 - charge increases were limited to 1/4th of the difference between the actual charge and 115% of the Medicare prevailing charge;

January 1, 1988 - charge increases were limited to 1/3rd of the difference between the actual charge and 115% of the Medicare prevailing charge;

January 1, 1989 - charge increases are limited to 1/2 of the difference between the actual charge and 115% of the Medicare prevailing charge; and

January 1, 1990 and subsequent years - actual charges may be increased to 115% of the Medicare prevailing charge.

OBRA-86 reduced prevailing charge levels for cataract surgery by 10% in 1987 plus another 2% in 1988. A limit of 4 base units for anesthesia services related to cataract surgery also was set. Special limits on fees for these services also were imposed, with actual charges limited to 1/2 the amount by which the charge exceeds 125% of the new prevailing charge in 1987 and to 125% of the prevailing charge in 1988 and thereafter.

The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) made further substantial modifications in Medicare payment for physicians' services:

Three-Month Freeze - Prevailing and customary charge levels were maintained at the levels in effect during 1987 during the three-month period ending on March 31, 1988. Also during this three-month period, MAACs were kept at the amount determined for 1987. 1988 MAACs did not go into effect until April 1, 1988.

Sequestration - The Gramm-Rudman-Hollings sequestration reduced payments for physicians' services by 2.324% through March 1988.

Medicare Economic Index (MEI) - For services provided by participating physicians after March 31, 1988, the MEI increase was limited to 3.6% for primary care services and 1% for other physicians' services. Increases for the services of non-participating physicians were set at 0.5% less than the increase allowed participating physicians (3.1% and 0.5%). For physicians' services furnished in 1989, the increase for participating physicians is to be 3% for primary care services and 1% for other physicians' services. The increase in 1989 for non-participating physicians will be 0.5% less.

Reductions in Prevailing Charge Levels - The following physicians' services provided after March 31, 1988 were subjected to "reasonable charge" reductions: bronchoscopy (Codes 31622-31626), carpal tunnel repair (Code 64721), cataract surgery (Codes 66830-66985), coronary artery bypass surgery (Codes 33510-33528), knee arthroscopy (Codes 29880-29881), diagnostic and/or therapeutic dilation and curettage (Code 58120), knee arthroplasty (Codes 27446-27447), pacemaker implantation (Codes 33206-33208), total hip replacement (Codes 27130-27132), suprapubic prostatectomy (Code 55821), transuretheral resection of the prostate (Code 52601), and upper gastrointestinal endoscopy (Codes 43235-43239). The 1987 prevailing charge levels for these services initially were reduced by 2%. Further reductions of up to 15% were implemented according to a sliding scale formula for services between 85% and 150% of the national average.

Where a non-participating physician's allowed charge is reduced by the application of this provision (or for cataract procedures, or physician supervision of certified registered nurse-anesthetists), the physician may not charge the beneficiary more than 125% of the reduced allowed amount plus one-half of the amount by which the physician's MAAC for the service for the previous 12-month period exceeds the 125% level. In subsequent years, the maximum allowed charge will be set at 125% of the prevailing charge. Where a physician "knowingly and willfully" imposes a charge in violation of this provision, the Secretary is authorized to apply sanctions (civil

money penalties, assessments, and five-year barring) against the physician. These charge reductions will not apply to services furnished after the earlier of December 31, 1990 or one year after the Secretary reports to Congress on development of the RVS.

Payment for Physician Anesthesia Services - In determining the amount allowed for the medical direction of two or more nurse anesthetists (in which services are provided in whole or in part concurrently) for services provided after March 31, 1988 and prior to January 1, 1991, the number of base units recognized for the medical direction (other than for cataract surgery or an iridectomy) will be reduced from current levels by: 10% where the medical direction is of two nurse anesthetists concurrently; 25% where the medical direction is of three nurse anesthetists concurrently; and 40% where the medical direction is of four nurse anesthetists concurrently. Where the anesthesia services are for concurrent cataract surgery or an iridectomy procedure provided after December 31, 1989 and before January 1, 1991, the number of base units that will be recognized for the medical direction will be reduced from current levels by 10%.

Fee Schedules for Radiologist Services - Medicare payments for radiologist services will be the lesser of 80% of the actual charge for the service or the amount provided under a fee schedule. "Radiologist services" are defined to include radiologic services performed by, or under the direction or supervision of, a physician who is certified or eligible to be certified by the American Board of Radiology, or a physician for whom radiologic services account for at least 50% of his or her Medicare billings.

Radiology Charge Limitations - Where radiologist services are provided by non-participating physicians or suppliers after 1988 and where payment is made pursuant to the fee schedule, the maximum amount that may be billed will be subject to a "limiting charge." The limiting charge will apply as follows: in 1989 - 125% of the amount specified in the fee schedule; in 1990 - 120% of the amount specified in the fee schedule; and after 1990 - 115% of the amount specified in the fee schedule. Where a charge is "knowingly and willfully" imposed above the limiting charge, sanctions may be applied

Limits on Payment for Ophthalmic Ultrasound - Effective for services provided after March 31, 1988, the prevailing charge level for A-mode ophthalmic ultrasound procedures may not exceed 5% of the prevailing charge level established for extracapsular cataract removal with lens implantation. Limits on actual charges for this service also apply.

Customary Charges for Services of New Physicians - For physicians who do not have adequate actual charge data, customary charges are to be set at 80% of the prevailing charge for the service in the area. (Previously, these charges were set at the 50th percentile of customary charges in the area, an amount usually above prevailing charge levels.) This limit is not applicable for primary care services or for services provided in designated rural areas.

December 15, 1988

Chart 1

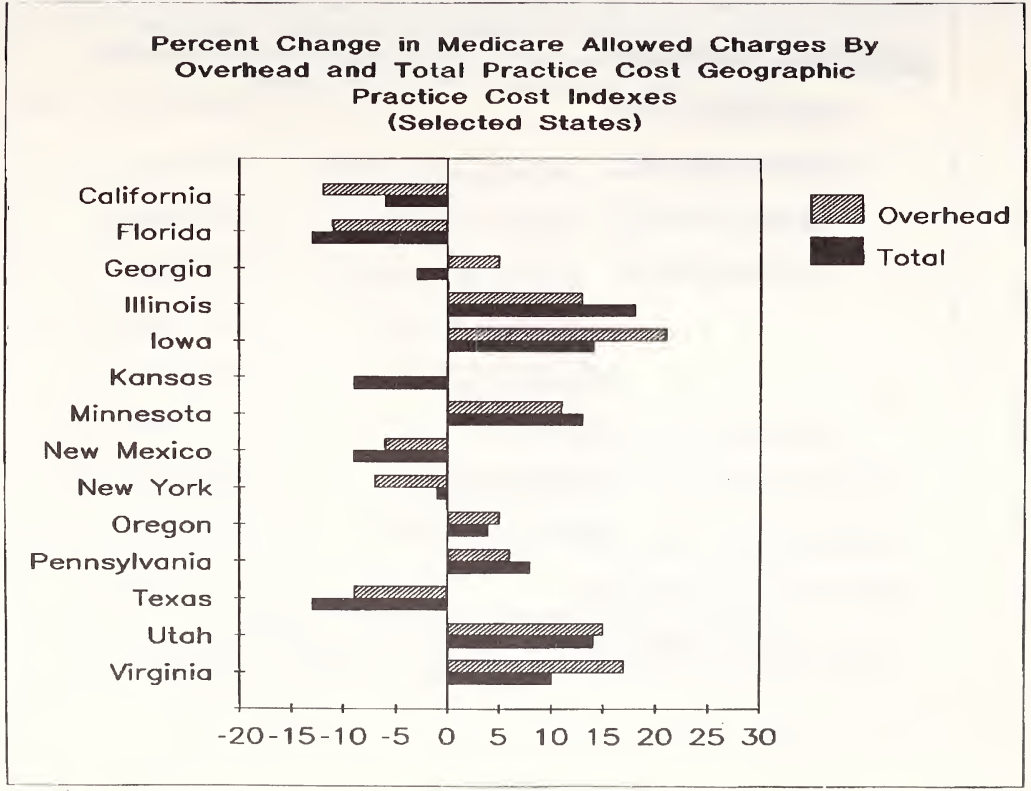

Percent Change in Medicare Allowed Charges By Overhead and Total Practice Cost Geographic Practice Cost Indexes (Selected States)
California
Florida
Georgia
Illinois
Iowa
Kansas
Minnesota
New Mexico
New York
Oregon
Pennsylvania
Texas
Utah
Virginia
-20 -15 -10 -5 0 5 10 15 20 25 30
Overhead
Total

Chart 2

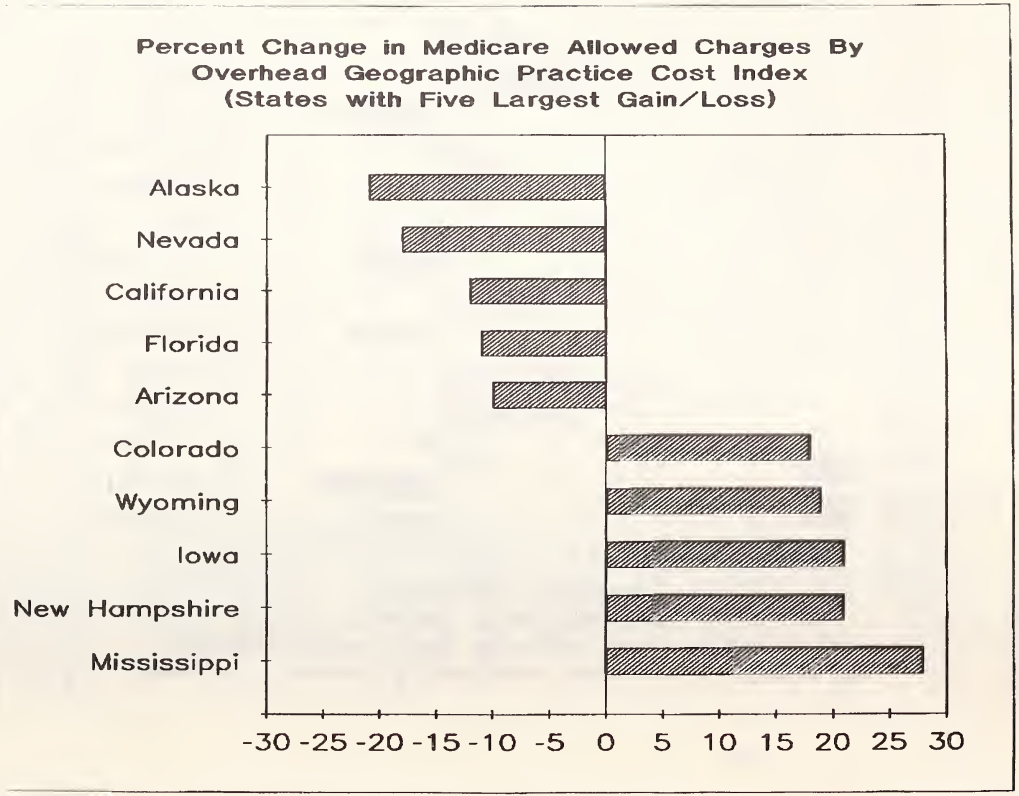

Percent Change in Medicare Allowed Charges By
Overhead Geographic Practice Cost Index
(States with Five Largest Gain/Loss)
Alaska
Nevada
California
Florida
Arizona
Colorado
Wyoming
Iowa
New Hampshire
Mississippi
-30 -25 -20 -15 -10 -5 0 5 10 15 20 25 30

Chart 3

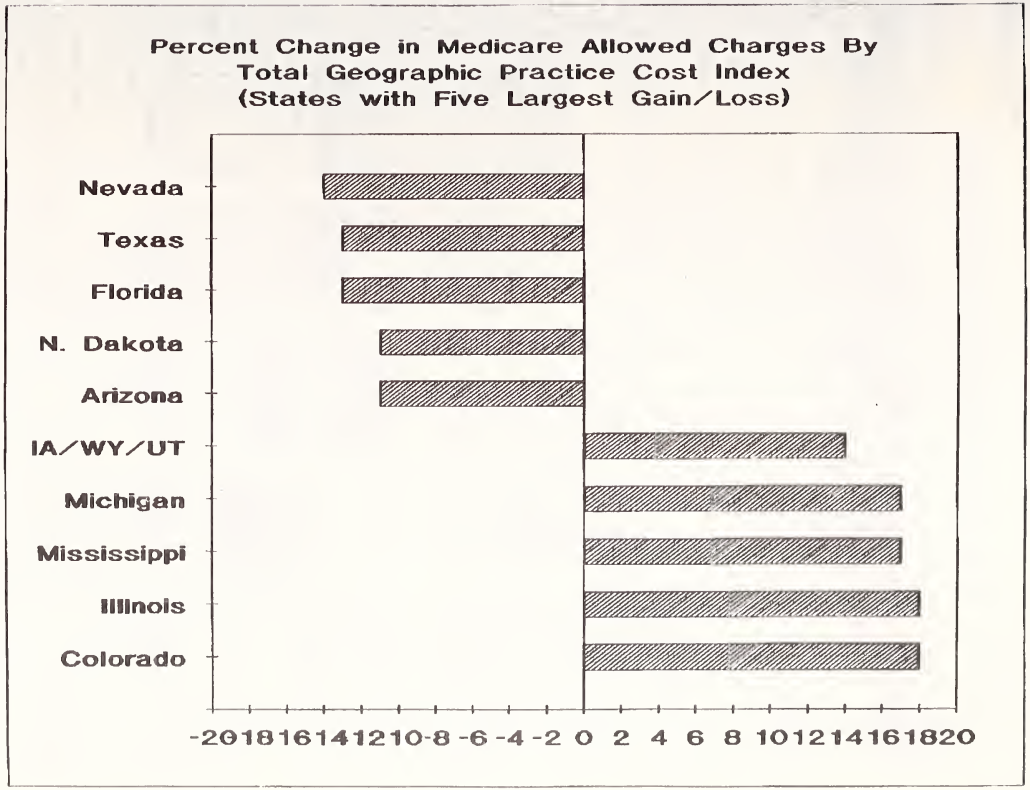
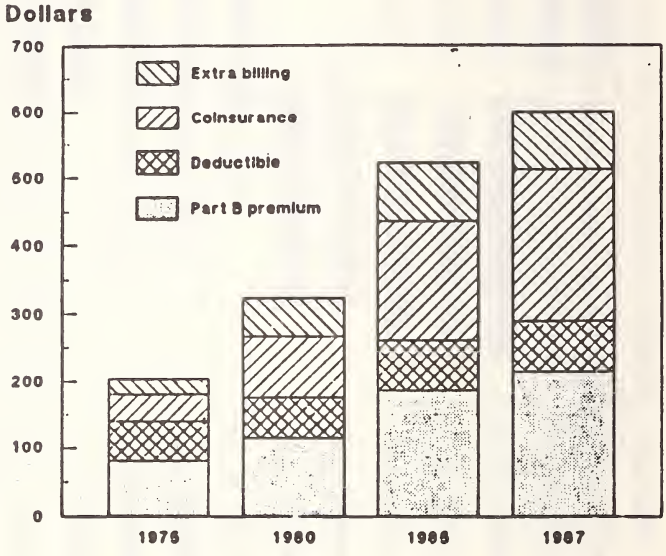

Percent Change in Medicare Allowed Charges By
Total Geographic Practice Cost Index
(States with Five Largest Gain/Loss)
Nevada
Texas
Florida
N. Dakota
Arizona
IA/WY/UT
Michigan
Mississippi
Illinois
Colorado
-20 18 16 14 12 10 -8 -6 -4 -2 0 2 4 6 8 10 12 14 16 18 20

CHART 4

AVERAGE ESTIMATED OUT-OF-POCKET COSTS PER AGED ENROLLEE FOR COVERED PART B SERVICES SELECTED YEARS: 1975-1987



SOURCE: HEALTH CARE FINANCING ADMINISTRATION OFFICE OF THE ACTUARY, DIVISION OF COST ESTIMATES

Mr. WAXMAN. Thank you very much, Dr. Ring.
Dr. Maynard.

STATEMENT OF EDWIN P. MAYNARD

Mr. MAYNARD. I am Dr. Edwin Maynard, president of the American College of Physicians and an internist in practice at the Massachusetts General Hospital. With me today is Deborah Prout of our public policy office in Washington.

First, we want to emphasize our support for enactment of legislation this year that will commit us to and begin the process of moving towards full implementation of Medicare fee schedule based on a resource-based relative value scale.

The Hsiao work is the culmination of a long process begun by Congress several years ago. While awaiting this report, piecemeal efforts to make short-term corrections have been enacted. Now it is important that you send a message that you are, indeed, in fact, serious about correcting the longstanding and well-documented inequities through a full-scale comprehensive reform of the system.

It is important to remember that this is not simply a matter of price equity but relates to the larger issue of creating the right environment for providing optimal care for patients. Time with patients, prudent management, appropriate services, simplified payments, and access to primary care, RBRVS constitutes far more than simply a shifting around of Medicare dollars.

The implications of RBRVS for access and manpower supply are worth noting. Many medical graduates today are choosing highly remunerative specialties and staying away from the primary care specialties. Geographic variations in payment are undercutting our ability to provide services in certain areas of the country.

Enactment of payment reform is an important element of assuring that young people continue to choose primary care specialties and to locate in areas of need in consonance with national policy.

Second, our full statement emphasizes the need to come to some common sense accommodation on the issue of Medicare assignment. This has been a political issue that threatens to derail urgently needed reform. Therefore, we applaud the PPRC for the significant work that they have done in elucidating the subtleties of assignment policy. Their studies make the point that "all or nothing" proposals on either side of this issue are too simplistic.

We strongly support the PPRC's recommendation that we absolutely protect individuals at low incomes. However, we would go further than their recommendation to protect so-called qualified Medicare beneficiaries, those for whom Medicaid pays cost sharing. We urge you to consider protecting beneficiaries at perhaps three times the poverty level. We also support and recommend to PPRC that there be appropriate limitations on balance billing for other Medicare beneficiaries.

The third and final area that we would like to address is the PPRC proposal for an expenditure target and future work on clinical guidelines. We are strongly opposed to the concept of an expenditure target. In fact, it is our only significant area of disagreement with the Commission's work.

The concept of an expenditure target runs absolutely counter to the policy premise of payment reform—that is, assuring that we pay an appropriate price for an appropriate service. The cap may be set too high and permit inappropriate services that could be addressed through more carefully structured approaches, or the target may be set too low and jeopardize the provision of needed services.

An artificial target avoids the central question of how much and what kind of care society requires. It is akin to old, short-term, broad-brush approaches of caps and freezes that do nothing to differentiate the good from the wasteful. We are deeply concerned that this is a quick-fix answer to a complex problem. We need to lay the groundwork for solutions to the expenditure problem that are consonant with the overall direction of payment reform and that are of lasting value. For this reason, we strongly support the use of carefully developed clinical guidelines in Medicare payment determinations.

As an interim measure, consistent with ongoing reform, it may be worthwhile to identify a small number of overutilized procedures for immediate efforts to reduce any unnecessary or inappropriate services. In selected areas, it may be possible to reach consensus quickly on what constitutes appropriate levels of service. It may be possible for the PPRC to work with the medical specialty organizations and recommend procedures for which physician-developed practice guidelines can be used as the basis for more appropriately focused utilization review.

Let me acknowledge that there are problems with this approach. The present state-of-the-art and utilization control is essentially punitive in nature. It is frequently intrusive and antagonistic in its questioning of a physician's professional judgment. Ultimately, reform of utilization control must be a part of overall physician payment reform. It should be based on what we know about how physicians change their practices and their practice patterns.

We must begin to create the conditions under which physicians will be able to do the right thing. These conditions will require an expansion of our present health services research capabilities, new knowledge of the effectiveness of medical practices, practice guidelines, which translate that knowledge for use by the practitioner, and a means of disseminating and implementing those medical guidelines at the local level.

We realize that the subcommittee will be considering these issues in greater detail at a later time. Development of practice guidelines is a longstanding activity of the American College of Physicians. Indeed, we have been at this for 13 years. For your purposes today, we would emphasize that it is a critical step in the overall package of payment reform.

We appreciate the opportunity to testify before you and look forward to working with you further.

[Testimony resumes on p. 102.]

[The prepared statement of Mr. Maynard follows:]

STATEMENT OF

THE AMERICAN COLLEGE OF PHYSICIANS

BEFORE THE

HOUSE ENERGY AND COMMERCE COMMITTEE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

May 25, 1989

THE RESOURCE-BASED RELATIVE VALUE SCALE

The American College of Physicians appreciates this opportunity to present the views of physicians in internal medicine and its subspecialties on the Resource-Based Relative Value Scale (RBRVS). With a membership of 65,000 general internists and subspecialists, the College is the largest medical specialty society in the country. I am Dr. Edwin P. Maynard, President of the College and an internist in practice at the Massachusetts General Hospital.

Introduction

Mr. Chairman, before we address the specific issues of the relative value scale, it will be useful to recall briefly the history of third party payment for medical services. It is important to remember that the first insurance, provided through the Blue Cross/Blue Shield companies, was established to provide coverage for hospital care. Services in physicians' offices were not covered. When these were later added, payment rates were set at low levels compared to the surgical services which were the primary focus of these policies.

When Medicare was established in 1965, Congress agreed to a payment system that would reflect prevailing charge patterns, in order to overcome

physician opposition to the program. Thus, the undervaluing of primary care from the Blue Cross/Blue Shield experience was mirrored in the Medicare program. The disparities worsened over the years: new procedures were developed and payments for them reflected the charge patterns of the physicians pioneering the technology; at the same time, the basic cognitive work of the physician - the office and hospital visit and consultative services - did not change substantively and there was little opportunity for these physicians to set new charge patterns.

In simplified fashion, this explains much of the inflationary spiral of Medicare's history: new procedures developed, fees set at initially high levels and never reduced, little chance to update fees for cognitive services, more and more pressure to perform more and more procedures, and little information on appropriate levels of service. The Congress has attempted to respond to this spiral through a variety of initiatives to restrain spending growth and its effects. You have placed limits on fees as a percent of prevailing charges, limited increases to the Medicare Economic Index (MEI), frozen and limited the MEI, created the participating physician program, and placed limits on actual charges.

The result of all this tinkering has been to create a nightmarishly complex set of rules and distortions in the system, but there has been little impact on costs. Further tinkering will not work. The basic system of customary, prevailing and reasonable (CPR) payments must be replaced. The system is inflationary. Out-of-pocket costs become an increasingly greater burden to the beneficiary, and program costs to the taxpayer rise by double-digit percentages annually. The CPR system provides inappropriate incentives for physicians' choices about what services to provide. It favors the inpatient setting over outpatient

alternatives. It favors urban and suburban areas over rural areas. It encourages over-specialization. It is extraordinarily difficult for providers and patients, and even program managers, to understand and cope with.

Recognizing these weaknesses of the CPR system, Congress directed the Health Care Financing Administration (HCFA) to undertake research which would permit Medicare to move to a payment system based on an objective measure of the relative value of physicians' work. Congress also had the foresight to create its own advisory panel for analysis and recommendations on these issues, and it can now call upon the expertise and wisdom of the Physician Payment Review Commission (PPRC) in developing legislation. Few, if any, similar blue-ribbon commissions have contributed so much to public policy debate in any area as has this Commission, and we commend Chairman Lee and all the members for their 1989 recommendations.

The Resource-Based Relative Value Scale

We now have the initial research results from the Harvard study, as well as the refinements suggested by the PPRC. For the first time, we have an objective measure which can be used to set Medicare payments. We have a measure that reflects the resources consumed to provide medical services.

This is intuitively an attractive concept: prices which are set to reflect the work and other resources that go into providing a product or service. With the use of such a measure, payments for all services will be established in correct proportion to the resources consumed, so that the payment system does not have incentives that favor certain procedures

and services over others. This kind of payment system would provide, in Dr. Hsiao's words, a level playing field.

According to the Harvard analysis, the physician's professional work is about half of the resources used in medical services. Measuring work was the major research problem facing the Harvard team, and their solution to that problem is the strongest and most important contribution of their study. They conceptualized work as time multiplied by intensity, and measured several dimensions of intensity in a large survey of physicians, using the technique of magnitude estimation. Dr. Hsiao and his colleagues present careful and convincing evidence that the survey of physicians to generate relative ratings of time and intensity for different clinical services has produced a set of values which were obtained by a reliable method and are reproducible, and which have a high degree of internal consistency and validity.

After intensive scrutiny, no one has found major flaws in the core of the Harvard work -- the development of an objectively measured scale of relative values. Those problems which have been identified - for example, the measurement of practice costs, coding inconsistencies for evaluation and management services, measurement of pre- and post-service work, specific problems for certain specialties - are being addressed by the Harvard researchers, the PPRC, and HCFA, and are expected to be resolved before implementation of a new fee schedule.

With the Harvard and PPRC results, there no longer can be any doubt that Medicare payments under the CPR rules have been based on factors other than the work involved, and that the rules favor high technology medicine over evaluation and management services. This committee has the opportunity to provide critical leadership in enacting payment reform to

develop a rational and equitable system that corrects the failures of CPR. We urge you to enact legislation this year to incorporate the RBRVS into a Medicare fee schedule.

Implications for Patient Care

We have heard it said that the RBRVS is simply a means of redistributing Medicare revenues among different types of physicians, so why should Congress be interested in carving up the same pie in a different way? We think you should reject this line of argument immediately. The RBRVS has profound implications for patient care. It may also have important implications for the size of that pie.

The American College of Physicians has long argued that the profession must assure that services to a patient are necessary and appropriate. The payment system has worked against this. By favoring high technology procedures and the inpatient setting over evaluation and management services and other settings, the payment rules have influenced clinical decisions. Especially in cases where clinically the choice of therapies may not be clear-cut, the CPR system has rewarded physicians for performing procedures rather than spending time analyzing, evaluating, diagnosing, and managing the patient's problem. It has thereby influenced physicians' medical choices.

By setting payments for all services in correct proportion to the resources and work involved, the RBRVS neutralizes the influence of the payment rules on the choice of therapy. Incentives are eliminated which lead to medical decisions influenced by factors other than the necessity and appropriateness of the service. This is the right environment for providing optimal care for patients. It is also an environment which may

help relieve the upward pressure on the volume of services, particularly the procedural services.

Secondly, an RBRVS-based fee schedule will highly simplify the payment system, so that patients will know in advance from the fee schedule what Medicare will pay for a service. That payment will be the same for all physicians in an area -- in sharp contrast to the present situation. The patient's anticipated out-of-pocket expenses will be clear, and that will help the patient decide whether he or she wants to request assignment.

Finally, the payment system appears to have a strong influence on physician choice of specialty. We must worry about access to internists and other primary care physicians, particularly in the next century as the elderly population swells. Medical graduates today are choosing highly remunerative specialties, and staying away from primary care specialties. The RBRVS can play a role in redressing this imbalance, by assuring the prospective internist that he or she will be compensated in the same proportion to the work involved as are all other specialists.

For all these reasons, Mr. Chairman -- time with patients, prudent management, simplified payments, and access to primary care -- we would argue that the RBRVS is good for patients, and much more than simply a shifting around of Medicare dollars.

In the remainder of our testimony, we would like to discuss a number of major questions that are addressed in the PPRC recommendations. These are issues that will be central to implementation of an RBRVS-based payment system.

Geographic Differential

We support the PPRC recommendation that the fee schedule should vary geographically to reflect overhead costs. Clearly, variations in the costs of practice are a critical adjustment that must be made in creating a fee schedule that is fair to physicians in different practice settings and in different parts of the country. It is consistent with a payment measure rooted in the resources consumed in providing medical services. We support a separate accounting of liability insurance expenses, so that the formula can be sensitive to the volatile nature of these costs and the wide differences in premiums among specialties and from one area to another.

We agree with the PPRC that an adjustment for earnings in addition to overhead is not consistent with the concept of a resource-based scale. We do not know why people locate where they do, what they value in an area, or how to turn that value into a monetary adjustment. Additionally, an adjustment which favors very large metropolitan areas may provide an incentive that runs counter to the existing policy goal of easing shortages of physicians in rural and other under-served areas and thereby enhancing access.

Having stated that as a matter of policy, however, we think that caution is well-advised in this area. There will be relatively large shifts in payments to physicians on the basis of relative value scores alone. If at the same time we eliminate the differentials among areas that are part of the CPR system - which reflects both overhead and earnings - the cumulative impact of these various shifts could lead to problems of access or decreases in assignment rates. Policy

recommendations and the timing of changes must be sensitive to these potential effects.

Assignment

The PPRC has produced excellent research on the issue of assignment and balance billing. The Commission has elucidated the subtleties of assignment policy and its impacts, and their studies make the point that all-or-nothing proposals on either side of this issue probably are too simplistic. The studies may point the way to alternatives around which a consensus might be formed. The conclusions we draw, however, go beyond those reached by the Commission.

The PPRC studies show that more than half of Medicare patients face no balance bill at all, and fully 80 percent have balance bills of no more than $50. With the steady increase in assignment rates, these percentages may be even higher today. The heaviest burden falls on a relatively small number of patients who are hit in three ways: they need a lot of care, they rarely get assigned care, and their balance bills are high in relation to Medicare's approved charge. In addition, balance billing differs among specialties and, to some extent, among types of service, and appears to increase with more expensive services.

With assignment rates approaching 80 percent, and large balance bills falling on a very narrow band of patients, the data indicate that across-the-board mandatory assignment is not necessary, and the College opposes this option. Physicians have obviously concluded that, in the large majority of cases, the Medicare payment should be accepted as payment in full. Second, why should a Medicare patient who can afford to pay the physician's customary charge be treated differently from a private-pay

patient or one who must pay a balance because his private insurance company's rates are less than the full charge? Third, even under the RBRVS, Medicare is expected to pay below the market in most cases. With the pressures on the federal budget, over the long-run a Medicare fee schedule may fall significantly below reimbursements made by other insurers. The retention of appropriate balance billing provides an assurance to providers if the gap between the market and Medicare becomes excessive.

The College believes there are two key elements to a reasonable policy on assignment. The first is to protect people who cannot afford the balance bill. The second is that assignment policy should be uniform. That is, it should be set by the government as the agent of society, not by physicians on an ad hoc basis. Our current system forces the patient to request assignment or forces the physician to depend on a person's clothing or address as clues to his or her financial status. This system allows two people of the same income status to be treated differently in two different doctors' offices, and that is simply not equitable.

Again, the PPRC data point the way to a solution. It is distressing to find that the voluntary assignment rate (i.e., excluding Medicaid patients for whom assignment is required) for ambulatory care is only 63 percent for patients below the poverty level. Even if the current level is higher, it is less than 100 percent, meaning that some of the poorest elderly patients still face balance bills. It is also distressing that the assignment rate for those in the range of 150-199 percent of the poverty level - still a low income level - is no different from the rate for patients at 300 percent or more of the poverty level.

The College believes that low income Medicare patients should not face balance bills. Therefore, as part of a reformed payment system, we support a federal assignment policy that is tied to income. While we do not have a specific recommendation on the income level which should be protected, we do not think the poverty level is sufficiently high. That level is only $5447 for a single elderly person and $6872 for a couple (1987 figures). A cut-off in the range of twice the poverty level would provide the protection of mandatory assignment for 35 percent of the Medicare population. A threshold of three times the poverty level would protect 54 percent of the elderly.

We suggest the Committee look to the experience of Rhode Island, Vermont and Connecticut in implementing income-related assignment policies, and also to the procedures that are established for setting the income-related supplemental premiums for the Medicare catastrophic coverage program. The fears of a stigma associated with an income-related policy can be minimized through the use of an encoded card; it is far easier for a patient to present this card to a receptionist or billing clerk than to have to make an assignment request to the physician or fill out a form.

Finally, tied to a revised policy on assignment and balance billing, another alternative that would provide additional protection for all beneficiaries would be to establish a highly simplified maximum charge. We endorse the PPRC recommendation that this be a fixed percentage above the fee schedule, and not vary by physician as does the current MAAC. This would bring a level of equality or balance to the system so that those above the income thresholds for assignment would not be paying disproportionately higher out-of-pocket expenses than low income

patients. It would protect those relatively few patients shown in the PPRC analysis to be caught at the high end of actual charges and percentage of balance bill. Finally, a maximum charge may be particularly necessary for those services which receive the largest reductions under the RBRVS. We would reiterate that such a limit in a reformed system must be far more rational and less cumbersome than the current MAAC.

Coding for Evaluation and Management Services

Research on the RBRVS has made it clear that the current procedural coding system is inadequate for describing evaluation and management services. While codes for technical procedures describe what physicians do, existing codes for evaluation and management services largely describe where it is done and to whom. Visits, for example, are described by type of patient (e.g., new or established), location of service, and sequence of the care (e.g., initial or follow-up). Levels of service (e.g., brief, intermediate, comprehensive) attempt to capture the duration and intensity of the service.

The problem is that these codes do not consistently describe or capture the same activities in the same way; the distinctions are not well defined, nor intuitively obvious. The result, found by the Harvard researchers and the PPRC, is that physicians in different specialties or even within a specialty use the same code to describe and bill for very different services.

Dr. Hsiao and his colleagues found that physicians' time is closely correlated with the work involved in evaluation and management services. On this basis, the PPRC has recommended that time be incorporated into the coding system, as a proxy for measures of content and intensity of

service. We believe this proposal is worthy of further examination, but we would be concerned that time as the sole measure may be prone to misuse or abuse, and less readily verifiable than other indicators. The use of time alone also raises questions about whether inefficient providers of services would be unfairly rewarded at the expense of efficient, highly experienced physicians.

We suggest that serious consideration be given to improvements in coding that rely on descriptions of the content of visits. Instead of describing visits as single services, description of the components of the visit would better capture the variety and complexity of visits. For example, case history, physical exam, evaluation services, preventive care, patient counseling, case management services, and literature review are potential elements of any single visit and vary as to their presence and intensity from one patient encounter to another. They are also readily understood by practicing physicians, thereby potentially heightening the consistency of coding.

Another important element that may help to distinguish the intensity of caring for one patient versus another is the age of the patient. It is well understood that our oldest patients, particularly the frail elderly, require more time to care for, and may be more stressful, even when other components of the visit may be similar.

The PPRC has undertaken an important study relevant to these questions. The PPRC will be asking physicians to keep records of their discrete activities in a log diary. This work should yield a fully detailed description of the work involved in the bundled complex of evaluation and management services. It holds the promise of forming the

basis of a set of content codes that have enough specificity so that each particular service is coded in one, and only one, way.

Content-based codes become particularly important if, as suggested by the PPRC, specialty differentials are eliminated in a new fee schedule. Specialty differentials have been used to capture differences in the value of physician services that reflect the physician's specialty training and experience. With an inadequate coding system relying on a few categories of visits and consultations, the specialty differential has been an important means of recognizing the training necessary to treat multiple and complex diseases involving many organ systems. To the extent that the complexity and intensity of the services rendered by these physicians can be described by a new, content-based coding system, the need for specialty differentials is reduced.

Budget Neutrality

The College believes that, given the need to reduce the federal deficit, it may be necessary for Congress to consider implementation of the RBRVS under conditions that are not budget neutral. The issue of budget neutrality appears to cause confusion. Many people hear this term and think it means no increase or decrease. As the Committee knows, budget neutrality means the full projected increase that would occur absent any change in law. For Medicare Part B, this is likely to be a double digit increase.

We think the RBRVS makes sense under any budget scenario, is essential to achieving payment reform, and that budget concerns should not derail us from implementation as soon as feasible. It is the right thing to do regardless of the spending total. While we would prefer a

conversion factor based on budget neutrality, we are not willing to lose long-term reform based on the RBRVS in a dispute over short-term spending levels.

Phase-In

In testimony to the PPRC, we opposed proposals for a phased implementation of the RBRVS. We particularly opposed a transition along the lines of the DRG model, in which a percentage of the CPR rate would be combined with a percentage of the RBRVS rate, and then shifted annually. That kind of transition would be enormously complicated, in an environment of tens of thousands of physicians' offices, with widely different billing capabilities.

The PPRC has recommended that, after passage of legislation to implement an RBRVS-based fee schedule, there be a two-year period in which the current CPR rates are adjusted in the direction of the RBRVS. This would be an adjustment similar to that accomplished in the 1987 Reconciliation Act, except that the RBRVS amounts would be used to calculate the percentage of the shift in each of the two years. Recognizing the need for the fee schedule to be as complete and accurate as possible, the College believes that such a transition would be relatively simple to implement, and would ease the shift to the fee schedule. Therefore, we support the PPRC recommendation, as long as it is tied to passage of legislation to fully implement an RBRVS-based fee schedule by a date certain.

Along similar lines, we would like to take the opportunity to comment briefly on the President's Medicare budget proposals for FY 1990. In 1987, during Congressional consideration of Part B spending proposals, the

College opposed across-the-board freezes or reductions, but supported proposals that would move in the direction of appropriate prices for all services - by cutting payments for services that were overvalued and increasing payments for those undervalued. Congress adopted this approach in the 1987 Reconciliation Act, reducing payments for specified overpriced procedures and setting a higher payment update for primary services than for non-primary services. We were pleased when the President's budget request for FY 1990 recognized the need to continue to correct the imbalance between primary and non-primary services. Enactment of these proposals would be consistent with the direction of reform under an RBRVS system and with the transition recommendations of the PPRC.

Controlling Volume: Expenditure Targets

Recently, when we have seen editorial or other comment on the need to control Part B costs, they are frequently prefaced with a note that Part A spending has been restrained.

It is worth re-calling the Part A solution when we think about the expenditure target proposed by the PPRC. The DRG system for hospitals has a simple, direct and straightforward incentive: Beat the fixed price per case, and you pocket the difference; exceed the fixed price, and you eat the costs. This incentive works not on a national level, not even on a regional or state level, but within a single hospital. The challenge is clear, the rewards and punishments are real and immediate, and the tools are within the control of hospital leaders.

Contrast this with the proposed expenditure target. The actions of an individual physician can have no visible impact on achievement of the

target. Any positive actions one individual takes may be negated by those of another person. The reward or punishment is vague and uncertain.

A second flaw in the proposed expenditure target is that the notion of meeting some arbitrary target says nothing about ensuring the appropriate level of care. The cap may be set too high, and allow a large amount of inappropriate care that might be eliminated through other mechanisms. Or the target may be too low, and jeopardize the provision of medical care for patients who need it. It is likely that the target would influence the practice behavior of those physicians who are already cost-conscious, while it is ignored by those for whom it is most intended. An artificial target avoids the central questions of how much, and what kind of, care this society is willing to provide.

Third, the concept of an expenditure target would appear to run philosophically and practically counter to the type of thoughtful, targeted approach in which Congress has shown increasing interest. It would appear to move us away from thinking in terms of appropriate price for appropriate services, and towards broad brush approaches of caps and freezes that do not differentiate the good from the wasteful.

Finally, the proposal assumes that the sole contributor to increases in volume is the physician. We would argue that patient demand is an important element, and that patients have to be brought into any workable solution to the question of utilization. Increasingly accepted precepts of patient autonomy challenge the old paternalism of the physician as sole decision-maker, and therefore, challenge the idea that the physician must be the locus of all utilization control strategies. Given the grey zones that exist in our knowledge base with regard to the effectiveness and appropriateness of various medical and surgical interventions, and the

choices that frequently must be made without any guarantee of a particular outcome, the highly personal preferences of the individual patient become critical decision factors.

While physicians still direct the use of most services, with the explosion of medical knowledge it is clear that utilization is also affected by patient expectations of levels and types of services (as well as by other influences such as insurance payment policies). This patient impact on utilization can only grow -- and should grow -- as patients become more knowledgeable about health matters. If we were to adopt new criteria of appropriate care without bringing patients into that process, they rightly would react with concern at being left out of crucial decisions.

We are beginning to know more about how to bring the patient into the decision-making process. Dr. John Wennberg notes that developments in media "provide revolutionary new ways for synthesizing, conveying, and individualizing information that can support a luxurious and active cross-communication between the patient and the physician" (Health Affairs, Spring 1988). This kind of interaction will dramatically enhance the role of the patient in medical decisions and take us further down the road of patient as enfranchised consumer.

Controlling Volume: Practice Guidelines

We have suggested as an alternative to expenditure targets the use of practice guidelines in Medicare payment determinations. The College, which has been developing practice guidelines since the 1970's, before other medical specialties, first brought to the attention of the PPRC the potential role of guidelines in controlling the volume of services. We

are pleased that the Commission has continued to recognize that potential. However, we believe the potential goes beyond the educational role discussed by the PPRC to a role in controlling inappropriate utilization of services that would have more immediate impact on Medicare spending than the proposed expenditure target.

The challenge in this area is not so much in creating good guidelines. We know how to do it, and more and more specialty societies are undertaking this responsibility. The problem is that we have only limited experience in the task of getting physicians to use the guidelines, that is, to change behavior from accustomed ways of practicing. There is some evidence that a central element must be education and follow-up, including peer pressure, that is brought to bear on a local level, either within a single hospital or in a community.

At this level, it appears that guidelines can have a significant impact on utilization. For example, the vigorous application of guidelines for respiratory therapy in a Boston hospital resulted in marked reductions in utilization, charges, length of hospital stay, and pulmonary complications, with no increase in morbidity or mortality. A similar effort at the UCLA Medical Center resulted in substantial reductions in the routine use of four labor-intensive and costly laboratory tests.

Until we know better how to change behavior, and can put into place these local mechanisms, a fiscal incentive will be necessary if we are to have significant impact on Medicare expenditures nationwide. We suggest that a proper role for government is to use physician-developed guidelines in payment determinations. We believe there is enough agreement in certain clinical areas to develop guidelines for practice that are backed by strong utilization review and payment denial where appropriate.

Neither Medicare nor any other payer should reimburse physicians for practices which the scientific evidence indicates are inappropriate in the particular case. These guidelines cannot be automatic screens, but should be used to highlight cases for review. The burden should be on the physician to show that the service was medically appropriate and payment is warranted.

We can choose several services and procedures now, and add new ones each year, for which research conducted under the College's Clinical Efficacy Assessment Project, or under the RAND studies, or by others indicates a high degree of inappropriate practice. We can publish and disseminate the guidelines, create the utilization review screens, and produce results quickly.

This is real to the physician. It is controllable. If the physician performs an inappropriate service, he or she does not get paid.

In proposing the expenditure target, the PPRC says the purpose is to elicit cooperative behavior among physicians in deciding on appropriate practices. If this is the purpose, why use that very remote mechanism? Why not simply start to identify those areas where research has been done, or is underway, and adopt professionally-developed guidelines as Medicare policy -- with the fiscal incentive of utilization review to back them up?

Conclusion

Mr. Chairman, you have the opportunity to enact legislation that will have profound impact on the Medicare program and the health delivery system generally. You have the expert advice of the PPRC to call upon as you formulate legislation. The American College of Physicians stands ready to assist in this task as well. We look forward to working with you to enact rational and equitable Medicare reform whose core is the RBRVS-based fee schedule.

Thank you for this opportunity to testify.

Mr. WAXMAN. Thank you very much, Dr. Maynard.
Dr. Graham.

STATEMENT OF ROBERT GRAHAM

Mr. GRAHAM. Mr. Chairman, I am Dr. Robert Graham, the executive vice president of the American Academy of Family Physicians. I do appreciate having the opportunity to appear before this subcommittee again to express our views on the subject before you.

We believe that the work of Dr. Hsiao and the recommendations of the Physician Payment Review Commission provide this subcommittee and the Congress with an important and historic opportunity to rebase the payment mechanism for physicians under the Medicare program in a manner which is more rational and more fully equitable.

Although the focus this morning and in the discussions of these programs in the last year have, understandably, focused on difficulties in areas of controversy, I think it is important that the subcommittee, in its consideration, recognize that, over and above physician payment reform, there are some other policy objectives which may well be served and accomplished by accepting the recommendations of the PPRC.

One, we believe that there currently exist marked and demonstrable disincentives in the payment system that discourage medical students from considering careers in general medicine. We believe that a physician payment reform will increase the numbers of individuals who will consider careers in family practice, general internal medicine, and that that will have a demonstrable improvement on the degree of access to services that our population needs both today and will increasingly need in the future.

Second, we believe that some of these payment reforms will make practice site selection more possible in rural areas for physicians than is present today and, indeed, may slow the present high rate of attrition of physicians from those areas. Thus, we believe, over and above the issues of payment reform and physician reimbursement that have been focused on thus far this morning, there are important other policy areas for the committee to consider in making its decision as to whether or not implementation in the immediate future is both necessary and appropriate.

You have before you our full testimony where we have gone into a great deal of specifics about some of the recommendations of PPRC and our responses to that. I will not try to duplicate those comments in my summary. I would like to touch upon several areas.

We support the concept of a single fee for a single service, regardless of specialist, regardless of site of geographic location. That is one area where we do have a minor disagreement with the PPRC. They have made some recommendations about changes based upon the geographic multiplier. We believe—and we have provided you the data in our testimony—that there is no demonstrable reason to vary the reimbursement based upon geographic area, upon supposed difference in practice cost. We believe the better data suggest that practice costs are higher in the rural areas.

We have proposed to use some mechanisms for beneficiary protection in implementation of an RVS. We do support, as the other speakers have, the development of practice guidelines, and we believe that this can be a shared responsibility with a group such as the American Medical Association, the specialty societies, and the PPRC.

We have made comments on what is clearly the more controversial of the issues before you today—expenditure targets. We share the same degree of concern and reluctance that the other speakers have shared with you thus far about the concept of expenditure targets, because we do believe it articulates for the first time in the public sector a decision to ration services to Medicare beneficiaries.

We do believe also, however, that that decision was made when the Congress first started following the reconciliation process, and we believe that the framework for the use of expenditure targets under the RVS that has been articulated by the PPRC may well be a more rational and fairer way to look at these rationing decisions than is presently the case under the reconciliation process. We have made comments in detail about that in our testimony.

I would simply conclude my remarks, Mr. Chairman, by saying it is the view of the Academy that implementation in a timely fashion, beginning this year, is correct. The issues before you are complex. There is not the degree of consensus that you might wish. I recognize it would make your job easier. But there is never going to be a degree of consensus in an area that is this complicated and is this fraught with natural and understandable differences of opinion.

We believe the recommendations of PPRC are, on the whole, sound and thoughtful. They are based on the very careful work of Dr. Hsiao. We hope you will not hold the good hostage to the perfect. The time to move is now.

Thank you.

[Testimony resumes on p. 118.]

[The prepared statement of Mr. Graham follows:]

STATEMENT OF AMERICAN ACADEMY OF FAMILY PHYSICIANS

I am Robert Graham, M.D., Executive Vice President of the American Academy of Family Physicians, the national medical specialty organization representing over 66,000 practicing family physicians, residents in training and medical students. On behalf of our members and their patients, I am delighted to appear again before this subcommittee to encourage you to enact legislation this year to reform Medicare physician payment with a fee schedule based on resource costs.

The members of this subcommittee are well aware of and sensitive to the problems in the current Medicare system. The "CPR" payment methodology is widely acknowledged to be highly inflationary, complex, unpredictable, inequitable, and fraught with perverse financial incentives. Medicare expenditures have experienced unrelenting growth, yet access to many important services remains a problem. Each year Congress has struggled to reduce Medicare Part B spending by enacting ad hoc budget cuts developed in the absense of an overall strategy for rationalizing Medicare policy.

Family Physicians have appeared before you on several occasions to state the many concerns of the American Academy of Family Physicians with the Medicare system. We have shared with you the difficulties experienced by communities with limited access to primary care services and by family physicians discouraged by an inequitable reimbursement system that undervalues many important medical services. You have heard this message from many distinguished witnesses, including Professor William Hsiao of Harvard. Today I appear before you to encourage you to enact a solution to many of these problems using the Harvard resource-based relative value scale (RBRVS) as the cornerstone of that solution.

RESOURCE BASED FEE SCHEDULE:

The American Academy of Family Physicians believes that a Medicare physician fee schedule based on the Harvard RBRVS offers greater potential to achieve meaningful physician reimbursement reform than anything that has been proposed in many years. We believe that such reform will benefit our patients by restoring a proper emphasis on primary care and encouraging the provision of disease prevention and health promotion services. Furthermore, we project that badly needed long-term improvements in access to primary care and prevention services will result from encouraging physicians to enter primary care specialties.

By estimating the resource costs of providing physician services, the RBRVS provides an approximation of the relative prices that would be achieved if it were possible to deliver physician services in a competitive market. In achieving this result we believe the RBRVS provides a framework for grounding Medicare physician payment squarely in the American economic tradition.

The Harvard RBRVS study has now been thoroughly reviewed by health services researchers, economists, and representatives of beneficiary groups, government, business and labor, and medicine. For the most part the study's results have been judged valid and reliable. Some methodological shortcomings have been identified and are being resolved by the Harvard team and/or PPRC in a timely manner. We specifically congratulate PPRC for its excellent work to refine the fee schedule, and to develop reasonable approaches to policy issues surrounding

implementation of a Medicare fee schedule. In particular, we are pleased with PPRC's conclusion that "when a service provided by physicians in different specialties is essentially the same, the payment should be the same." Furthermore, the Academy supports incorporation of time into the description of visit codes, to promote more accurate use of codes for these evaluation and management services. We believe that a resource-based Medicare fee schedule as developed by Dr. Hsiao and his team and as modified by PPRC is sufficiently developed to allow Congress to move in an expeditious manner to reform Medicare physician payment this year.

The results of the RBRVS study suggest that current payments for many physician services are severely out of balance in relation to the resource costs of providing those services. A resource-based fee schedule would revaluate physician services in a manner favorable to primary care and rural areas. The redistributive impact of adopting a resource-based fee schedule would be consistent with previous Congressional actions providing higher MEI updates for primary care services and underserved areas, placing floors under the prevailing charges for primary care services, and selectively cutting the prevailing fees of some high-volume, overpriced procedures.

As you know, there is a significant and persistent shortfall in the supply of primary care and rural physicians relative to the need for their services. The United States has a smaller proportion of primary care physicians than any other developed country (13 percent of U.S.

physicians are family physicians as compared to 53 percent general/family physicians in Canada). Inadequate reimbursement has proved to be a major disincentive for physicians to choose these types of practice and has resulted in severe access problems for some Medicare beneficiaries. By correcting the existing inequities in Medicare physician payment, an RBRVS-based fee schedule will, in the long run, encourage more physicians to choose primary care specialties and rural practice locations.

Recent PPRC simulations of the redistributive impact of a resource-based fee schedule suggest that the Medicare income of family physicians will on average increase by 30 to 40 percent. This is considerably less than the 65 to 70 percent increase projected by the Harvard team last Fall. It is important to recognize that, on average, approximately 10 percent of family physicians' income is derived from the Medicare program. Furthermore, family physicians typically provide a broad range of services, some of which will undergo a fee reduction under a resource-based fee schedule.

Geographic Multiplier

The PPRC recommends that the Medicare fee schedule by modified with a geographic multiplier that is intended to reflect geographic differences in the cost of practice. While we recognize that PPRC's recommendation for a geographic multiplier would eliminate much of the existing geographic differential in Medicare prevailing charge screens, it is our position that there should be no differentiation in physician fees based

on practice location. This payment policy is grounded in the belief that equivalent service should result in equivalent compensation.

The urban/rural differential in current Medicare prevailing fees has compromised beneficiaries' access to medical care. Lower fees have discouraged physicians from locating and maintaining their practices in rural areas. Furthermore, low approved charges affect physicians' willingness to accept assignment for Medicare claims and result in higher relative out-of-pocket expenses for rural beneficiaries.

Geographic differentials continue to be justified on the presumption that there are geographic differences in the cost of practice and that urban practices are more expensive to operate than rural practices. The PPRC has recommended utilizing a geographic multiplier that is intended to reflect geographic differences in the cost of practice. PPRC has based this recommendation on a study done for HCFA by the Urban Institute.

The conclusion reached by PPRC is contradicted by Medical Economics and AMA data which show the cost of rural practice to be higher than in other locations. Recent AMA data indicate that mean professional expenses for rural physicians are $6,000 higher than for physicians in the largest metropolitan areas. Medical Economics surveys indicate a stable pattern of higher professional expenses for rural physicians both in terms of

actual dollar amounts and as a percentage of gross practice revenues. The following chart shows annual practice expenses for urban, suburban and rural physicians in terms of dollar amounts and as a percentage of gross practice revenue. The dates in parentheses indicate the dates on which this data were published in Medical Economics.

Year	1982 (3/5/84)		1984 (11/11/85)		1985 (11/10/86)		1986 (9/7/87)		1987 (9/5/88)	
	$	%	$	%	$	%	$	%	$	%
Urban	52,350	35.4	61,810	36.9	60,000	36.3	60,870	43.0	91,540	43.0
Suburban	53,980	37.8	66,780	38.8	69,220	39.0	72,750	47.2	96,310	45.6
Rural	56,070	38.8	63,330	39.8	69,500	43.8	73,500	51.8	98,050	47.8

In taking a broad look at the body of data available on practice costs it is apparent that there is no compelling evidence of any systematic variation in practice costs, i.e., there is no objective support for implementing a geographic multiplier in a Medicare physician fee schedule. A valuable lesson on this matter is available to policy makers from the implementation of the Prospective Payment System (PPS). When PPS was designed in the early 1980s, certain assumptions were made about the relative costs facing urban and rural hospitals. Because it was assumed that urban hospitals face significantly higher input costs, an urban/rural differential was built into DRG reimbursement rates. The disastrous consequences of having made that assumption are now being felt by hundreds of rural communities. Much effort is now being expended to undo the unintended effects of a faulty and unfounded assumption regarding relative

costs. Policy makers would be well advised to exercise due caution before making a similar unfounded assumption in reforming Medicare physician payment.

Imposing a geographic multiplier on a Medicare fee schedule lacks merit on several counts. It is inconsistent with federal policies that incorporate uniform national rates, such as federal income tax, social security payments, and the Medicare Part B premiums. Second, no systematic, significant, and reliable differences in the cost of urban and rural practices have been demonstrated. The cost-of-practice index proposed by PPRC is based on proxy measures of the prices faced by physicians in running their practices and yields results that are in marked contrast to surveys that have directly measured physicians' costs of practice. Furthermore, the index incorrectly assumes that the costs of medical equipment, repairs, and transportation do not vary geographically, and it fails to consider the unavoidable necessity of maintaining a larger standby capacity in rural practices. Third, there are non-quantifiable cost of rural practice, such as being on call virtually at all times, that obviate any rationale for higher reimbursement rates in urban areas.

Updating the fee schedule

The Academy believes that the Physician Payment Review Commission will continue to have an important role under a reimbursement system with a resource-based fee schedule. Specifically, the Academy recommends that

PPRC have a defined role in working with the American Medical Association and individual medical specialty societies in annually updating the Medicare fee schedule. The process should include frequent and regular monitoring of practice costs, and updating to reflect changes in practice costs which are anticipated because of potential changes in Medicare reimbursement for some services.

FINANCIAL PROTECTION OF MEDICARE BENEFICIARIES:

Family physicians understand the financial burden that health care can place on Medicare beneficiaries. Patients make known their fears about rising health care costs and share their uncertainty about Medicare payment policies. The Academy believes that any new Medicare reimbursement system should be fair to beneficiaries.

Simulations by the Physician Payment Review Commission suggest that, on average, out-of-pocket expenses for beneficiaries will decrease under a resource-based Medicare physician fee schedule. However, hidden in these highly aggregated averages is the potential for some beneficiaries to experience significantly increased expenses. For this reason the Academy supports measures to protect beneficiaries both during the transition to and after the implementation of a fee schedule.

During the proposed transition to a fee schedule we anticipate that prevailing charges will move toward the projected fee schedule amounts. As these modifications are made, it is imperative that Medicare beneficiaires be protected from excessive balance billing for those services for which the fee is reduced. This can be accomplished by limiting the total amount which physicians can charge to a specific percentage of the prevailing charge, such as 125 percent. This strategy has been utilized by Congress in implementing limits on "over priced" services and therefore would be consistent with current policy.

The Academy supports two strategies for protecting beneficiaries after the fee schedule is in place. This first proposal is aimed at protecting the most financially vulnerable elderly. Assignment should be required for all services provided to Medicare beneficiaries whose income is below two times the poverty level. This proposal goes somewhat beyond the PPRC proposal that calls for assignment for services provided to "qualified Medicare beneficiaries" covered by Medicaid.

The second strategy is to limit balance billing by all physicians for all services to Medicare beneficiaries not covered by the above proposal to 125 percent of the fee schedule amount. These limits would replace the current Maximum Allowable Actual Charge (MAAC) limits. The Academy believes that limiting balance billing to 125 percent of the fee schedule is an equitable balance of the interests of beneficiaries and physicians.

For reasons noted in our comments below on expenditure targets, the Academy's support of these beneficiary protection provisions is contingent on the understanding that there will be annual aggregate fee schedule updates which fully account for legitimate increases in the cost of practice, increased number of beneficiaries, the aging of that population and technological advances. The balance of interests must continue to be equitable for the program to remain viable.

CONTROLLING VOLUME:

Practice Guidelines:

During the transition to the fee schedule, practice guidelines, also known as clinical policies, should be developed by and made available to the medical community to assist in identification of unnecessary and inappropriate services. The Academy is highly supportive of outcomes and effectiveness research and believes that this information can assist physicians in this increasingly complex medical climate to understand the most efficacious ways to practice medicine. The Academy already is working to establish clinical policies for family practice in concert with Dr. David Eddy at Duke University. We believe that practicing physicians will be able to use this information to provide optimal medical care to their patients. We encourage Congress to authorize and appropriate federal funds to support extramural research in this highly important effort.

The Physician Payment Review Commission, however, while supporting effectiveness research, has recommended utilizing expenditure targets as an integral part of an overall strategy for moderating the growth in volume of physician services through a reduction in unnecessary and inappropriate services. The AAFP believes that the Medicare fee schedule may help reduce inappropriate increases in the volume of services by correcting incentives for overuse in the current payment system. We understand, however, that a fee schedule alone may not fully address these problems.

The Academy believes that a decision to utilize expenditure targets as a means of moderating increases in Part B expenditures represents an explicit decision to ration services to Medicare beneficiaries. It is a change from the perception of current policy, which is that unlimited resources are available to meet beneficiaries' needs.

An expenditure target that caps physician expenditures in the aggregate would not automatically distinguish between limits on effective or ineffective services nor between appropriate or inappropriate services. We have concern therefore, that an expenditure target scheme unless targeted to specific classes or categories of "overused or overpriced" services could have the untoward effect of markedly decreasing access to basic, day to day services.

A recent examination of Medicare claims data for calendar years 1983 through 1986 demonstrates a very uneven pattern of growth in the volume of services. While the per beneficiary volume of primary care services (such as office visits) has increased little, if at all, volume has increased rapidly for surgical and diagnostic procedures. Three kinds of service grew at above average rates: surgery, radiology, and specialized diagnostic tests such as electrocardiograms, cardiac stress tests, and echocardiography. Together these three types of service account for two-thirds of the increased spending. In sharp contrast to the increases in surgery, radiology, anad diagnostic tests, total number of office and hospital visits per beneficiary changed very little.[1] If Congress decides that the only feasible way to control costs is through expenditure targets, the Academy proposes that the targets be implemented in an way that minimizes the impact on access to primary care services, by ensuring the appropriate distribution of limited resources. Further, if Congress believes that it should proceed with this strategy, the Academy would propose that separate expenditure targets should be established for specific services or categories of services that have a high cost and high volume profile and for which there is a large element of physician discretion.

There continues to be a need for improved beneficiary access to primary care services. Congress in previous years has recognized the need and has taken specific action to encourage provision of these services (higher

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[1] J.B. Mitchell, et.al., "The Medicare Physician Fee Freeze: What Really Happened," Health Affairs (Spring 1989).

MEI updates for primary care servies and for underserved areas, and a floor under the prevailing charges for primary care services). Conversely, Congress has adopted cuts in the prevailing fees for some high-volume, over-priced procedures. We believe that Congress should once again look at the public policy objectives of improving access to primary care services and take this into account when considering an expenditure target approach to limit Medicare spending.

At this point there are serious questions about how an expenditure target approach would be implemented and its impact on the health care system. For example, we are concerned that present liability climate could undo the intended effect of various efforts to reduce the volume of minimally benefical services. Under the existing civil justice system, if a patient is harmed as a result of withholding a service that has any probability of benefit, no matter how small, it is difficult to defend that decision in court. The fear of incurring a liability action and the incentives posed by expenditure targets influence decisions about rendering services of minimal potential benefit in opposite directions. In no case should expenditure targets be applied until the resource-based Medicare fee schedule is fully in place. The effects of the targets should then be carefully monitored.

SUMMARY:

The message that I would wish to leave with you today is a positive one, one of hope. Congress is presented with a unique opportunity to enact meaningful reform of Medicare physician payment this year. The excellent work of Dr. Hsiao and his team and of the Physician Payment Review Commission provide a firm base on which to rationally restructure Medicare. A resource-based fee schedule would create a level playing field for physicians, provide for a health care system that is more balanced in terms of the specialty and geographic distribution of physicians, moderate the growth in Medicare expenditures, and, most importantly, ensure much improved access of beneficiaries to appropriate medical services. The American Academy of Family Physicians urges you to enact Medicare physician payment reform this year.

Mr. WAXMAN. Thank you very much.

Let me start off my questioning with Dr. Ring. The AMA made a fairly strong endorsement of RBRVS in Dallas last winter. You did so, even though some people have characterized RBRVS as merely redistributing income among the various specialties. If that is all it is, my colleagues might well wonder why we should bother to implement it.

Do you agree with that characterization? How could the AMA, representing all sizes and shapes of physicians, endorse it under those circumstances, and does it represent more than just a redistribution of wealth?

Mr. RING. It does represent more than a redistribution of wealth. It represents a rationalization of the reimbursement system.

As you have heard many horrendous examples of inequities in the system, irrationalities in the system, we believe that an RBRVS system such as Harvard's, when it's properly refined and expanded, constitutes the best method of rationalizing a system that can best be described as chaotic.

Mr. WAXMAN. I know you have reviewed the Hsiao results very carefully. Have you found any major flaws in it?

Mr. RING. We think there should be refinement and revision of the pre- and postservice work measurements; there should be expansion and validation of the current extrapolation methods; we think that development of relative value estimates for global surgical services can be improved up—and there's a half-a-dozen others.

We think the study is a fine one. We don't think it includes enough specialities at this time. We think that, when it is refined, corrected and improved upon, it will constitute a superb basis for rationalizing a presently irrational system.

Mr. WAXMAN. Dr. Maynard and Dr. Graham, both of you appear to be saying that we know enough already to legislate the basic structure of RBRVS and begin the transition. It may make sense to phase it incautiously in order to resolve additional issues and monitor the effects, but the time is ripe to begin. Is that reasonably accurate of what you would say to us?

Mr. GRAHAM. It is for us, sir.

Mr. MAYNARD. It is for us, too. We believe the time is to move now for the initial implementation.

Mr. WAXMAN. Dr. Ring, your testimony is not as clear on this point, but it seems to say that we should hold off on legislation until further research and analysis have been completed. If that's accurate, what are your concerns about our beginning now by using the RBRVS to make marginal adjustments in the current payment levels, at least for those services which the Hsiao and PPRC results seem valid?

Mr. RING. Our concerns would be—I think the reaction to the recent HCFA release of the geographic analyses, which came in with some astounding surprises, such as rural States coming out on the short end of the reimbursement pile and, indeed, with reductions in their Medicare reimbursement, we think this is a matter of concern and it should be studied.

It is clearly stated by HCFA that this is a preliminary estimate, but if this is true, and we rush willy-nilly into the development of an RBRVS based on something that would cause the degree of

chaos that's predicted in that report, I think we would not be serving the American people very well.

Mr. WAXMAN. There seems to be some disagreement among you on how we should address the RBRVS among geographical areas. Dr. Maynard, you agree with the PPRC view, that we should adjust for differences in practice costs but not for differences in cost of living. Would you elaborate on the policy objectives entailed in your position?

Mr. MAYNARD. Yes, we are fundamentally in agreement with the PPRC recommendation, that for a given service the payment should not vary, either from specialty to specialty or from area to area. There are very real differences in practice costs that can be introduced into an appropriate formula to be derived through the RBRVS process.

Mr. WAXMAN. Dr. Graham, in your testimony you seem to disagree. Would you elaborate on your views?

Mr. GRAHAM. We do disagree by a degree. Our concern is that the measures that are being used thus far for estimation of practice cost—and this is certainly part of the HCFA database which led to the report earlier this week—are using proxy economic measures that are predominantly cost-of-living measures to interpret what different practice costs might be for physicians in different regions. On the other hand, as you see in the testimony we have presented to you, there are specific data which have to do with samples of physician practice cost, not proxy economic measures, which suggests to us that the cost of practice for physicians in rural areas is higher than it is in urban areas.

That leads us to believe that the best place to start with implementation is equal fee for equal service, wherever it is delivered. If better specific data at some point in the future can demonstrate actual practice cost differences, then they ought to be looked at and considered in the whole resource cost formula. But we think the better argument and the better data today is equal fee for equal service, wherever and by whomever.

Mr. WAXMAN. Dr. Ring, what's the AMA's position on this?

Mr. RING. AMA's position is that where there are differences in the cost of generating the services, geographic and specialty differentials are possibly justifiable. We think they should be minimized.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

I would like to start with this question that we were talking about with out last panel, the relationship of the practice guidelines and the expenditure targets. Let me ask each of our witnesses, the three physicians specifically:

Do you and your organizations believe that expenditure targets are needed to motivate people to do the practice guidelines? Dr. Ring.

Mr. RING. Speaking for the AMA, no, we do not. I think the development of parameters for appropriate care—and I use the word "parameters" advisedly—we cannot develop a cookbook for care and apply it to every patient down the line. Care for patients has to be individualized. But it can be individualized within the guidelines of broad parameters of what is appropriate care for a given condition.

I don't think that we need expenditure targets to stimulate the medical profession to develop that. Indeed, the AMA is proceeding apace to develop these guidelines now. We have established an office of quality assurance and we are in the process of developing those.

Mr. WYDEN. So we have one representative who favors the adoption of practice guidelines without the expenditure targets. How about your organization, Dr. Maynard?

Mr. MAYNARD. We are of the same view. We do not support an expenditure target as an organization, and I must say that I, as an individual practicing physician, would view a national expenditure target so far removed from me and my decisionmaking that it would be hard for me to see in any way that this would influence my particular decisions.

However, practice guidelines, towards which the College has been devoting a large proportion of its own efforts and expenditures for the past 13 years, are really being increasingly demonstrated to have a major impact on physician behavior. This is the way physicians learn. They learn from well-studied, published guidelines generated by their peers, and this is the way they change their practices.

Yes, these are used currently in an educational mode, but it would be quite easy to translate this at a future date to be used as a payment benchmark as well.

Mr. WYDEN. Dr. Graham.

Mr. GRAHAM. I believe the subcommittee should separate its discussion of practice guidelines and expenditure targets. I am not comfortable with the degree of linkage that Dr. Lee's answers led you to. I was reflecting on his comments as he was making them, and I think that perhaps he and I both spent too long working in Washington and it becomes possible to believe that the only motivator is an economic motivator.

I agree with Dr. Ring. I believe that physicians will respond to good information, to provide better medical services, without economic incentive. I believe the whole reason that expenditure targets is on the table in front of you is a separate and separable reason, and I believe you should disaggregate them.

Mr. WYDEN. But your organization will pursue the development of practice guidelines?

Mr. GRAHAM. We have and we are.

Mr. WYDEN. Mr. Chairman, I think this is a particularly important point that I would like to work with you and the staff on, because there is a clear difference of opinion at this point. Dr. Lee, in effect, says you need the expenditure targets to get into the development of practice guidelines. I think that is an open question myself and would very much like to work with you on it.

Just one last question. Dr. Ring, I am still unclear with respect to whether the AMA would like us to try to begin this session, as we go into the next few weeks, to implement an RBRVS. Is it the opinion of the AMA that we should try, for example, in this session, to at least make these marginal adjustments in payment levels, where there is some agreement? Is that the view of the organization, that we should begin to do that, based on the fairly widespread agreement, in this session?

Mr. RING. The American Medical Association's position is that we don't believe it should be developed in this session. We believe there is additional information that the Congress needs. Studying should be completed before we start to act on it.

Mr. WYDEN. You have given a blunt answer.

Mr. RING. Thank you.

Mr. WYDEN. And I appreciate it.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Bruce.

Mr. BRUCE. Thank you, Mr. Chairman.

I wondered, Dr. Maynard, you mentioned in your testimony in the beginning about utilization review, that much of it is punitive in nature, but at the same time you express concern about physicians and their right to practice in a way they deem appropriate and who would not get involved.

What is your suggestion on utilization review, then? If you're not going to be proscriptive and say these are the cookbook approaches, these are the five things that you can do and charge for, it seems to me that utilization is almost after the fact, unless you want to get into saying this is the way each patient must be treated for this condition.

Mr. MAYNARD. I think I indicated in our testimony that we believe the basis for improved utilization review procedures and techniques can be derived from more widely applied and better constructed practice guidelines.

In our specialty of internal medicine, we have been busily generating these in a wide variety of areas. We have published guidelines on the use of common diagnostic tests. We are now generating ones for common screening procedures. These are the ways in which not only the physicians can be guided in the utilization and volume control of procedures and services, but they can also be used, once generated, by more rational and applicable utilization review services and payment decisions.

Mr. BRUCE. Again, though, how would the utilization review panel work unless it's a punitive measure?

Mr. MAYNARD. Well, it could be, in a sense, a punitive measure. If it's clear that a given physician's practices are outside those guidelines and beyond the norm, then they can have payment denials made accordingly.

Mr. BRUCE. In answer to Representative Wyden's question, you mentioned that you didn't think the expenditures target as a personal practicing physician would have much impact, since it's a national target.

What would be your reaction, however—one of the proposals is that we set the expenditure target, and if you exceed that by 10 percent in any given year, then the next year we reduce that expenditure target by 10 percent the following year. As a sole practitioner among thousands of physicians, if you knew that next year your income would be cut by 10 percent if you overutilized it by 10 percent this year, then what decisions would you make in your office?

Mr. MAYNARD. This would have a significant negative impact on my services, and I would be quick to add that, as an older physician, practicing in a State with mandatory Medicare assignment, I

already am very much aware of the impact of State and Federal policies on physician income for somebody in the primary care services.

This is where we are suffering in my State, because we are having great difficulties in attracting younger physicians into the State because of the difficulties in earning a living in primary care practices.

Mr. BRUCE. Dr. Ring, what do you think a physician would do if we say, if you exceed the expenditure target in any year, we take that out of the coming year, the year following, that we reduce the expenditure target by that amount?

Mr. RING. I think it would have a chilling effect on medical practice. Like Dr. Maynard, I'm a practicing physician, and my primary responsibilities are to my patients. My ethical responsibilities are to my patients.

If actions are taken that adversely impact the care I am able to give the patients, I would inform my patients of that. I would give them John Porter's phone number and say call your representative because this is what's going on. But my obligation is to tell that patient what is in his or her best interest. Whether or not the government or any other payer will pay for it is another matter.

Mr. BRUCE. Dr. Graham, you mentioned that you did not support any particular geographical fee alteration. In the testimony of Dr. Lee, he mentioned in PPRC that they had a special category for malpractice coverage where there is variation, mentioning Florida and Utah, I think, in his testimony, and Idaho, as the few States who have greatly varying malpractice rates.

Would that meet your test that you kind of talked about, if you had known factors, that you could put those in as geographical differences?

Mr. GRAHAM. On the specific issue of malpractice, we have supported the Commission's suggestion that that be treated separately, because there can be such demonstrable regional variance on a particular resource cost.

Could I respond very quickly to the two questions you asked previously?

Mr. BRUCE. Yes.

Mr. GRAHAM. I think it should be made clear that I believe the difference between what Dr. Maynard is explaining and what we have now is the difference between clinical guidelines and administrative guidelines. The type of PRO review and sanction that is occurring today, that our members see, that we get letters and letters and letters in Kansas City about, are administrative sanctions that have nothing to do with quality medical practice. The imposition of the development of basic quality clinical guidelines, that could be used as part of legitimate care review, I think all of our associations stand behind.

Mr. BRUCE. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bruce.

Thank you all very much for your testimony. We look forward to working with you.

We would like to call as our next witness Perham Amsden, American Association of Retired Persons. We are pleased to have you with us, Mr. Amsden. Your prepared statement will be entered

in the record in full. We would ask you to limit your oral presentation to no more than 5 minutes.

STATEMENT OF PERHAM AMSDEN, VOLUNTEER, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. AMSDEN. Thank you, Mr. Chairman. I am Perham Amsden. I'm a volunteer, living in Maine, working for and supporting the American Association of Retired Persons. I also happen to be a beneficiary representative on the Maine peer review organization.

AARP appreciates this opportunity to present its views on physician payment reform. My written statement outlines in detail our assessment of the Commission's report. I will only outline the key points here today.

First, we begin with the premise that the purpose of Medicare is to provide beneficiaries financial protection for access to needed health services. Payments to physicians are a means for achieving that objective.

Second, AARP continues to support a resource-based relative value scale. Much work has been done over the past few years to lay the groundwork for reform of the Medicare system of payment to physicians, and more can and needs to be done. But, in our view, it is time for Congress to enact a new system based on the Commission's recommendation for a resource-based relative value scale.

We will never have all of the answers that we might want to have, but we should take the next step. But, at the same time, we urge this subcommittee to bear in mind that any change in payment rates, even if budget neutral in the aggregate, means that beneficiaries will be affected differently. Simply put, I do not visit my doctor in the aggregate. Rather, I have specific medical needs and visit specific doctors.

For example, raising the payment for primary care services, a good result under the resource based relative value scale, may also encourage doctors to perform more primary care, but my coinsurance will rise. How much will it rise and how will this impact my access to care? Just as some physicians may be paid more and others less, so, too, some beneficiaries may pay more and others less. So, as with physicians, there will be beneficiaries who will be winners and losers.

Third, AARP recognizes that volume is a key issue. While some would suggest that beneficiaries are responsible for increasing in volume—what they like to call beneficiary-induced demand—I would simply point out to you that the doctor and not the patient is the decisionmaker concerning what services will be performed. In fact, the one area where beneficiaries have discretion—initial office visits—has remained stable on a per beneficiary basis over the past decade.

Much of the current, out-of-pocket cost of part B services paid by beneficiaries in the form of premiums and coinsurance is increasing. One of the many reasons is because of increases in the volume of services. The part B premium has risen 91 percent since 1984. Coinsurance is now over $7 billion, having increased from just over $2 billion in 1981. Understanding the impact on the beneficiary

and making adjustments where needed should accompany reforms in the payment system.

I might add at this point that the Association does not support the Bush administration's proposal to extend the requirement of premiums equal 25 percent of the cost, over which they have no control.

AARP has long been concerned by evidence of wide variations in physician practice patterns and high levels of unnecessary or inappropriate surgery. AARP strongly supports a strategy of making significant investments in research on medical outcomes. The dissemination of information and the development of practice guidelines is one method to control volume of services. Such a strategy, to succeed, must have the support and active involvement of the physician community and the beneficiaries. Determining what is effective care is essential before moving forward with other means to control volume. In our view, appropriate quality care and concern for costs are complementary, not mutually exclusive goals of any new system.

Another approach favored by the PPRC is a national expenditure target. While AARP approaches the concept of expenditure targets cautiously, the design is a useful one. The Association has many questions, such as how will an expenditure target be implemented, and how will it impact the non-Medicare purchases of health care—for example, through cost shifting. From the beneficiary perspective, volume must be controlled, and beneficiaries will want to be part of further discussions about expenditure targets.

Fourth, monitoring access to care and the impact on beneficiaries is crucial to any reformed system. This information will be vital in refining the payment system over time and ensuring that we have met our goals of providing financial protection and access to care.

Fifth, any change in the payment system should be implemented in a transition period of perhaps at least 5 years. Because of the complexity of this issue, we feel a gradual transition will let us evaluate the steps we are taking and avoid sharp increases in beneficiary out-of-pocket costs.

Sixth, beneficiary protection is important to prevent cost shifting to beneficiaries. We strongly support the continuation of the participating physician PAR program and balanced billing limits, and we view these as transition steps toward mandatory assignment. Once fair and rational fees are achieved, why should a physician be permitted to balance bill any patient for what is above and beyond a fair fee?

We applaud the Commission for recommending that physicians be required to file potential claim forms with Medicare. This step is important in streamlining the system for beneficiaries and ensuring that they receive the benefits they are entitled to.

Finally, Mr. Chairman, we realize that pressure to reduce the budget deficit will continue through the years to come. We urge that when this subcommittee designs a new payment system, that the system be able to accommodate attempts to achieve budget savings without harming the integrity of the system. AARP looks forward to working with this subcommittee.

[Testimony resumes on p. 150.]

[The prepared statement of Mr. Amsden follows:]

STATEMENT

OF THE

AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman, and members of the Subcommittee, I am Perham Amsden, an American Association of Retired Persons (AARP) volunteer. I have served on AARP's Health Care Campaign Advisory Committee, and am the beneficiary representative on the Maine Peer Review Organization (PRO).

We appreciate this opportunity to appear before the Subcommittee to present our views on physician payment reform.

AARP continues to support the goal of revising Medicare's physician payment methodology through the use of a fee schedule based on a resource based relative value schedule (RBRVS). We have had the opportunity to review a number of physician payment issues from the beneficiary perspective with the Physician Payment Review Commission (PPRC), in hearings and in meetings with their staff.

Our testimony today covers several areas: 1) problems with the existing payment system; 2) recent actions in physician payment reform, and the beneficiary community's interest in controlling the growth in Part B expenditures; 3) AARP's perspective on payment reforms, the fee schedule revisions suggested by the PPRC, and the need for a better understanding of the impact of payment proposals on beneficiaries; 4) other important elements of the PPRC plan -- elements that are necessary to any payment reform plan -- such as beneficiary protections and volume restraints; 5) the American College of Surgeons' proposal; and, 6) a summary of what AARP sees as the key elements which need to be incorporated in any physician payment reform initiative.

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Background

Physician payment reform has generated a complicated, technical debate among government policy and budget officials, researchers, and physician specialty and subspecialty associations. That debate is vitally important, but we think it useful to go back to the basics when assessing issues as complicated as physician payment reform.

AARP approaches this issue with what we hope is not a novel premise -- that Medicare exists to assure financial access to health care for the 33 million elderly and disabled individuals insured under the program. Medicare has brought to its beneficiaries access to care generally comparable to the rest of the population and provided financial protection for the cost of covered services. But rapidly rising costs are eroding that protection.

For me and for 33 million other Americans -- and for the rest of the population as they age -- Medicare is not a technical policy issue -- it is our health insurance plan. It was enacted because the nation recognized that a Federal social insurance program -- Medicare -- was appropriate and necessary to support health benefits coverage for the aged and disabled, with Medicaid providing means tested coverage for the poor. The reason was, and remains, that the traditional vehicles for support of health benefits are less available to the elderly. For example, federal tax incentives provide substantial governmental support for the many younger, working individuals in employer-based group health insurance -- at a cost estimated at about $30 billion in tax expenditures in FY 1990. That support and numerous other

advantages of group health benefits are less available to elderly persons.

Problems with Existing Payment System

AARP believes that there are five fundamental problems with the existing payment system that must be addressed:

- The payment system has been inherently inflationary since its inception in that payment levels rise with the increase in billed charges (subject to some constraints);
- The fee-for-service methodology encourages the provision of an increasing volume of visits and tests;
- The payment methodology reflects -- and contributes to -- numerous distortions in the medical care market, often based on the charging patterns existing in the early 1970s. These distortions account for unjustifiable differences in fees among different types of services, and among different locations.
- The system does not provide adequate financial protection to beneficiaries against charges over and above what Medicare determines to be reasonable; despite recent improvements in this regard, physicians still have the option to extra-bill the beneficiary after Medicare has decided on the charge which it determines to be reasonable.

- Finally, the system is enormously complicated for beneficiaries, physicians, and the government to understand, to receive payment under, and to administer. Could any member of the Subcommittee give a description of the method for determining the reasonable charge, assignment, or the computation of the MAAC limits? Yet every day, beneficiaries and physicians have to try to wend their way through this very system.

Recent Actions, and Beneficiary Interest in Controlling Expenditure Growth

Over the past few years, the Congress has addressed a number of these issues. The creation of the Physician Payment Review Commission was an effort to begin working toward long-range reform of the system. In addition, shorter-term legislative actions have been taken as well. Congress has imposed a number of constraints on physician payments -- and has always accompanied those constraints with beneficiary protections. Those protections are particularly important because they help assure that the federal savings in payments for physicians' services are not shifted to the beneficiary in the form of increased extra-billing. The participating physician (PAR) program and the maximum allowable actual charge (MAAC) limits have helped to increase the assignment rate. Equally important, they provide a framework that, with enhancements, can help protect the beneficiary from having payment reductions passed on to us under any future payment reforms. Let me state clearly that in any further reform of the system, beneficiaries should

share in any savings achieved.

The PPRC's March, 1988 report provides a useful graph, which I have attached to my testimony, which highlights the fact that the beneficiary protection initiatives (PARs and MAACs) have slowed the growth in extra-billings -- which until recently had been the fastest growing portion of out-of-pocket payments by beneficiaries under Part B. Given continuing and enhanced financial protections against extra-billings, the most serious financial problem that beneficiaries now face in Part B of Medicare is that overall spending continues to grow too fast. This is an important issue for beneficiaries because we share substantially in the cost of that spending growth through Part B premiums, deductibles, coinsurance, and taxes.

For example, annual Part B premiums have increased 91 percent since 1984 -- from $175.20 to $334.80, exclusive of the monthly catastrophic coverage premium that all Part B enrollees will pay.

AARP believes that any physician payment reform, assuming protections against extra-billing, must be more than simply adjusting payment levels to create greater equity among physicians. Reform must also address rapid expenditure growth under Part B of Medicare. In fiscal year 1988, beneficiaries paid $1.8 billion for the Part B deductible, and $7.14 billion in coinsurance. As a beneficiary who pays for a substantial portion of Part B payments through my premium, deductibles, coinsurance, and taxes, I want to be sure that overall spending restraint is included.

It is important to note that the spending growth that we see in Medicare is not some rapid increase in so called "beneficiary-induced demand." The staff of the Congressional Budget Office estimated in December, 1988 that the increase in Part B spending from 1988 to 1990 was derived from three sources: price increases (19 percent); population increases (23 percent); and utilization/intensity increases (58 percent). These utilization/intensity factors include physician-induced demand (partially to accomodate to price constraints), unbundling and provision of more complicated services, and technological advancements. If there were any increase in patient-induced demand, it would be a subset of this number.

However, increases in patient-induced demand are not likely a large factor in the remaining spending increase. As I discussed earlier, there are substantial financial barriers to such demand -- the initial deductible, the 20 percent coinsurance, and the extra-billing. The physician is generally the decisionmaker when it comes to the provision of medical services.

As the Subcommittee is only too well aware, the pressures to achieve savings in Medicare will continue into the forseeable future. Whatever new system you devise must not only provide a far more rational system, but also be able to accomodate future federal budget pressures without harming the integrity of the program.

AARP Views on Payment Reform

As I noted earlier, AARP continues to support reform in Medicare's physician payment methods in order to enhance the ability of Medicare to provide financial access to health services, and financial protection for beneficiaries for the cost of those services. The initial phase of the debate on physician payment reform has focused on adjusting payment levels among types of physicians' services and the geographic areas in which those services are provided. That is, of course, an important policy and technical issue, and one of great interest to the various segments of the physician community. The debate on how best to implement Medicare's fundamental purpose -- the protection of beneficiaries and the assurance of continued access to affordable care -- has just begun.

RVS Revisions, Practice Costs, and Geographic Multipliers

A great deal of work has been done by PPRC and others to quantify, assess, and revise payment schedules for physician services. The original Resource Based Relative Value Schedule (RBRVS) developed at Harvard has been subject to a great deal of debate, and the PPRC has developed substantial modifications in the Harvard methodology. These include revisions in the method of determining overhead and practice costs, elimination of specialty differentials, and the use of global fees.

AARP concurs with PPRC's recommendation that a practice cost index reflect only overhead costs. We are concerned, however, that the potential impact of a geographic multiplier on beneficiaries' cost-sharing has not been carefully analyzed. In

principal, since Medicare is a national health insurance program, beneficiaries should be provided equal financial protections and burdens for similar services wherever they reside. The precise means by which legitimate variations in cost should be included requires further work. It is reasonable to assume that some type of geographic adjustment is necessary to account for differences in costs such as rent and labor.

While the impact of some of these changes remains unclear, the Commission's continuing efforts and future plans to revise the fee schedule methodology will be important if the Congress chooses to make use of the RBRVS approach in enacting physician payment reform.

Impact on Beneficiaries

While most of the debate and technical revisions have centered on issues concerning the physician community, AARP believes that it is equally important to recognize and assess the beneficiary impact of the relative value scale as well as other reform possibilities before you proceed.

The beneficiary impact of revising the fee schedule arises because a fee schedule changes the payment rates, and therefore the coinsurance rates. Thus, when you hear about payments for certain procedures or services, or in certain areas, being raised or lowered by 10 percent or 20 percent, you should recognize that you are making similar changes in coinsurance.

This concern about the coinsurance effects of fee schedule changes may appear to be self-evident, but it must be assessed carefully, because the payment changes create provider and

beneficiary incentives which conflict. If you raise the amount I have to pay in coinsurance for primary care services, making those services more costly for me to receive, you tend to impose an increased financial barrier to my seeking care. Yet a major thrust of the RBRVS seems to be to encourage the provision of that same primary care service by increasing the provider's payment for primary care. The physician may be more likely to provide the service, but the patient is exposed to a greater financial barrier to that same service, which may make them less likely to seek the care. This is an important issue since primary care is typically the entry point to the medical system. This could impose the greatest problems for chronically ill persons who need frequent physician visits. Comparable problems arise as payments increase and decrease in specific geographic areas. For example, if payments in certain rural areas are increased, as they would be under the PPRC approach, coinsurance for individuals in those areas increases as well, again creating potentially conflicting physician and patient responses.

Extra-billing and assignment implications also need to be understood and assessed carefully. Increases in payment rates may make it less likely in the short-term that some physicians would extra-bill, while decreases would appear to make it more likely that others would extra bill. Thus, these effects could offset some of the coinsurance effects, but it is not at all certain. For the elderly beneficiary whose coinsurance for a service is <u>definitely</u> increasing, a <u>potential</u> decrease in extra-

billing is small solace. AARP believes that specific constraints on extra-billing must be included to make sure that beneficiaries benefit through reduced extra-billing when payment rates (and coinsurance) increase, and do not have fee reductions shifted to them in the form of increased extra-billings.

In our testimony to the PPRC and our discussions with them, AARP has asked that the Commission develop beneficiary analyses as part of their review, for two reasons. First, we want to be sure that the Commission itself assesses beneficiary impact as part of its deliberations, much as it must of necessity consider the impact of various proposals on various specialties of physicians. Second, the beneficiary analyses can provide information for the Congress and others that is useful in making assessments and decisions about payment reform.

Beneficiary Simulation

The PPRC has developed a beneficiary simulation which was included in their report to the Congress.

At this point, AARP appreciates the fact that the PPRC has made progress in assessing the beneficiary impact, but much of the analysis remains at relatively large "aggregate" levels. We need to look more precisely at the impact of specific payment changes on beneficiaries, not only in the aggregate but also on subgroups. Patients do not visit a physician in the "aggregate." I encounter specific medical problems and need to see specific doctors. What will be the impact on me and my neighbors, whose need for care may be quite different? For example, how will coinsurance and extra-billing change for an 80 year old woman

living in a rural area who needs primary care services? What about a beneficiary living in an urban area, who requires surgical services?

Most of the PPRC models assume no change in billing, "participation", assignment, volume and access. However, much of the underlying rationale for developing a revised payment system appears to be based on the assumption -- and goal -- that we want to change some of these behaviors. The change in payments now envisioned would appear to be based on an implicit assumption that fee increases will increase use and access to evaluation and management services, and to services in certain geographic areas, such as rural areas.

While, on average, beneficiaries will fare as well under the proposal as they do today, the reality is that some will do better and some worse, and AARP has asked the Commission to assess more precisely these effects. How many would be better off, and how many worse off? What are the characteristics of the "winners" and "losers" -- for example, beneficiaries who are subject to higher or lower coinsurance as a result of the payment schedule changes, or beneficiaries whose access might change?

The Commission, AARP, and the Congress need to understand the characteristics of those beneficiaries who will see their cost-sharing increase or decrease because of reform proposals, and determine if provisions should be incorporated into the plan to minimize those effects. We urge the Subcommittee to act on reform but to do so with a clear understanding of the implications for beneficiaries most affected by the plan. Further, we urge the Congress to implement any reform on a

gradual, phased basis over a period of up to 5 years, in order to minimize abrupt changes in payments for either beneficiaries or providers.

Revised fee schedules such as those developed by the PPRC have unknown but vitally important implications for the volume of services provided by physicians, beneficiary access to specific types of services in specific geographic areas, and quality. Like extra-billing, the potential implications and physician responses are the subject of much speculation, but difficult to test empirically.

While it may not be important that we agree on simulation models which project what might happen in areas such as volume, access, and even extra billing, the policy process should be able to identify what we want to have happen -- for those are presumably among the reasons that the payment rates are being changed. It would appear to us to be valuable to state explicitly certain goals in these areas -- such as goals for increased volume and access for certain services, and in certain areas, and increased assignment rates or decreased extra billing amounts. No new system can guarantee achievement of all its goals immediately. Monitoring will be necessary to determine if the goals and assumptions on which the new system is based are in fact being met, and, if not, what further policy changes might be necessary.

We were pleased to see that the PPRC included a monitoring strategy in their recommendations. We urge the Congress to include and appropriately fund such a monitoring initiative as

part of any payment reform that you develop. And, we ask that you go even farther, and set and define explicitly the goals and assumptions about volume, access and use, and beneficiary financial protection on which you are basing the revised system, and then use the monitoring system to assess whether those goals are being met.

Beneficiary Financial Protections

AARP believes strongly that one objective of physician payment reform should be the creation of fair and rational fees. Once fair fees are achieved, extra-billing should no longer be permitted. AARP views balance billing limits and the continuation of the Participating Physician (PAR) program as transition steps to mandatory assignment.

The PPRC recommendations include some steps to provide financial protection for beneficiaries from the cost of extra-billing. AARP is generally supportive of the PPRC recommendations to set some upper limit on the amount of extra-billing on unassigned claims, so long as those limits enhance the financial protection afforded by the current MAAC limits. In addition, the AARP supports the PPRC recommendation to maintain the PAR program.

Qualified Medicare Beneficiaries

We are very concerned about the PPRC recommendation for limiting mandatory assignment for "Qualified Medicare Beneficiaries" (QMBs). These are individuals with income below the federal poverty level identified under the recently enacted Medicare catastrophic coverage act. State Medicaid programs have

to "buy" such individuals into Medicare coverage by paying their premiums, deductibles, and copayments, but do not have to provide Medicaid coverage for them.

As you know, Mr. Chairman, AARP has long opposed any effort to means- or income-test benefits under the Medicare program. Medicare has achieved a quarter century of success as a social insurance program for the elderly and disabled, with Medicaid the appropriate vehicle for means-tested health benefits.

AARP believes that any effort to means-test Medicare benefits would lead to the undermining of the social insurance foundation on which the program is built. Administratively, means-testing would be a nightmare, if not impossible. It is our understanding that when the Congress provided for the Medicare buy-in for the qualified Medicare beneficiaries, you did not consider them as eligible for Medicaid benefits. AARP does believe that all classes of Medicaid beneficiaries should be treated alike for purposes of assignment.

Assignment when the beneficiary has no choice of providers

Another assignment proposal by the Commission appears to be more promising. PPRC has proposed mandatory assignment for services for which the beneficiary has no choice of provider. While the specifics of such a proposal need to be developed, it is a concept that AARP would be able to endorse. We would include hospital-based physicians' services, as well as other situations in which there is no choice of practitioner.

Claims Forms

Finally, we were very pleased to see that the PPRC included a recommendation that physicians submit claims for all beneficiaries directly to Medicare, which would greatly facilitate the administrative process for beneficiaries. We believe physicians should not be permitted to charge for filing claim forms, and that these PPRC recommendations are necessary steps for streamlining the program for beneficiaries. In implementing such a procedure the Committee should examine what the increased cost to the program would be since those claims which are not now filed -- the so called "shoe-box" affect -- would be filed by providers under such a plan.

It is important to note again that we believe that all of these beneficiary protection initiatives should be viewed in the context of our longer range goals in this area.

Volume Issues

AARP recognizes that a fee schedule alone will not address the continuing increases we see in the volume of Part B services. As noted earlier, little is known about the impact of a revised fee schedule on volume.

Practice Guidelines

One constructive step to address volume issues was outlined by the PPRC in their recommendation for enhanced research on medical outcomes and development and dissemination of practice guidelines. Such an approach can help assure that physician payment reform leads to longer-term redirection of medical services to the more effective modes of treatment. We support

enhanced investments in these efforts as a means of stimulating the longer-range reforms desired.

While adoption of a resource based relative value scale may help increase the rationality and fairness of the unit price paid by Medicare for covered physician services, it is not sufficient to resolve the problem of rapidly rising expenditures by Medicare and indicates that rapid increases in the volume and intensity of services provided per enrollee explain much of the increase in Part B costs. Therefore, the key to controlling Part B expenditures is to reduce the volume of unnecessary or inappropriate care.

AARP has long been concerned by evidence of wide variations in physician practice patterns and high levels of unnecessary and inappropraite surgery. We believe that the work of Wennberg and researchers at RAND merits serious attention. We also believe that the medical community has an obligation to develop and adopt practice guidelines based on the best available evidence of optimal clinical practice.

The Association strongly supports the strategy of making significant investments in research on medical outcomes, the dissemination of information, and the development of practice guidelines. We see this as a central element of any physician payment reform, because it is directed toward assuring that the medical services provided to Medicare beneficiaries -- and all other patients as well -- are effective and appropriate. We believe that Congress can best foster these goals through support of professional consensus-building initiatives.

Such a plan should include, at a minimum, the following elements:

- o investments in research on medical outcomes, on the effectiveness and appropriateness of care, and on the measures that may be taken to improve these results;

- o enhancements in our public and private data bases to facilitate research and the implementation and monitoring of practice guidelines;

- o development of practice guidelines and dissemination of those guidelines through the provider community and the beneficiary community.

It is important to highlight certain key features of any such initiative from our perspective.

First, to be successful, we believe that any such initiative must be viewed as a sustained, long-term investment by the government and the provider community. The research to date indicates significant variation in practice patterns across the country, and the exciting potential for us to assess the outcome effects of alternative types of medical care. However, we should all recognize that it will take time to develop and disseminate the substantial body of knowledge required to revise practice patterns appropriately, and we should commit ourselves to making the long-term effort required.

Second, it is vitally important to develop some agreed-upon definition or criteria for "effective" and "appropriate" care.

We believe that it is imperative that the defintion reflect functional improvements and quality of life criteria as well as scientific and technological criteria. Furthermore, we need to establish the value of results in deciding on future care approaches. Thus, we would envision a broad-based group representative of beneficiaries, providers, researchers, and others, which would be involved in arriving at initial definitions and criteria for assessing effectivenss and appropriatness, setting standards, monitoring results, and revising those definitions as technology, practice, and standards change.

Third, the guidelines development process requires a careful blend of Federal initiative and provider and beneficiary involvement. We believe that the Federal government must take the lead in initiating and financing the research and guidelines development effort, establishing processes through which priorities can be established, and incorporating guidelines into Federal programs like Medicare and Medicaid. At the same time, the physician community must be intimately involved in the development and dissemination of any guidlines in order for those guidelines to be acceptable to the practitioner community -- and we would stress that the beneficiary community must have a substantial involvement in that effort as well. All of us recognize that there will be continuing tensions among the participants -- government, practitioners, researchers, private payors, insurers, and beneficiaries -- and we suggest that the Congress should therefore focus initially on structuring a

decision-making and priority-setting process which can help to balance the diverse points of views. It is important that whatever guidelines are developed include a process for documented and legitimate exceptions to the norm. Since medicine inevitably requires the exercise of judgement and a high degree of uncertainty, some deference must be given to the physician in doubtful situations.

Fourth, we would stress that the Congress not look to this research and guidelines development effort solely as a vehicle for achieving savings. Enhanced knowledge about what care is most appropriate will undoubtedly identify circumstances where efforts should be increased because appropriate care is not provided, as well as cases in which inappropriate care is not provided and should be cut back.

In the long run, providing all necessary services and not providing unnecessary services should both improve quality of care and reduce overall costs.

Expenditure Targets

A second approach to dealing with volume is through expenditure targets, and the PPRC has recommended moving to a national target based on volume of services per beneficiary.

While the framework of PPRC's proposal may be supportable and is certainly a more useful approach than other options studied by the commission, AARP has several fundamental questions about the implementation and impact of targets on our overall health care system.

- First, numerous questions arise about implementation of the concept. How are the targets computed, set, enforced, and responded to by the physician community? How would physicians in a community or a specialty assess their progress toward a volume target? What decisions might they make if volume is too high, or too low, compared with the target? How do they arrive at these decisions? Equally important, how does the individual physician respond? How do targeted volume reductions apply to an individual physician providing services to an individual patient?

- Second, it is vitally important to understand the implications of any reductions in access to services which might arise in response to a target. Volume reductions mean that visits, procedures, or tests are not performed. What specific services, in what areas, and for which patients, are reduced to meet a target?

- Third, what role will beneficiaries have in the setting, implementation, and response to a target. From the beneficiary perspective, if Medicare spending in my community is subject to some limits, I want to be represented in decisions about how the community will respond to those limits. Even with the best of intentions, the way the government and physician community may wish to respond to the targets may not be in the beneficiaries short- or long-term interests.

- Fourth, what will be the impact of expenditure targets on the overall health care system. Other countries which have such targets have national health insurance systems, while in this country we have multiple purchasers of care. How would Medicare expenditure targets effect the cost and access to care of the Medicare population and non-Medicare population? Would savings be shifted to the non-Medicare population, raising the price of their care? Such cost shifts would raise the cost of employee health benefits. As this Committee knows, the tax treatment of such benefit costs means that the cost-shift would result in increased tax expenditures for such benefits.

In the area of expenditure targets, as well as other elements of any reform plan, substantial transition periods as long as 5 years may be required to provide for informed implementation and to avoid abrupt changes.

American College of Surgeons Plan

In addition to the PPRC proposal and variants of a resource based relative value scale, an alternative proposal has been suggested by the American College of Surgeons (ACS). While AARP appreciates that fact that ACS has recognized the need for some moderation in the rate of increase in Medicare spending for physician services, we have a number of concerns with their plan.

AARP believes that any physician payment reform proposal should address all physician services -- not be limited to specific specialties. Reform may apply different rules and

standards to different services, but should be comprehensive in its approach. Thus, whether you decide on the PPRC proposal, the ACS approach, or some option to be developed, we urge you to apply payment reforms to all physicians services.

To address some of the specifics of the ACS proposal, AARP must first state our firm opposition to the ACS proposal to means-test assignment policy. AARP would support Medicaid expansions as the appropriate means for enhancing benefits for the low-income elderly and disabled, but will adamantly oppose any effort to means-test Medicare benefits, because means-testing benefits undermines the foundation of social insurance on which the Medicare progam and Social Security Security are based.

The second assignment-related provision in the ACS proposal is mandatory assignment for surgical services when the beneficiary has no choice of providers. AARP regards this as a more promising initiative once the specifics are developed. In addition, we appreciate the fact that the surgical community is not advocating the concept of an "indemnity" fee schedule which is traditionally advocated by the physician community. As you know, Mr. Chairman, an "indemnity" schedule is the technical description used by the physician community to describe a fee schedule under which Medicare sets the fees but the physician is free to extra-bill the beneficiary whatever he or she can get away with.

AARP is also unsure about the effect of the ACS proposal to blend "demand" side factors with resource price factors in determining the relative value schedule. It is unclear to us how

those factors would be defined and quantified.

Finally, we view the ACS volume initiatives in much the same way that we discussed for the PPRC proposal. We support the idea of developing practice guidelines, but are unsure how expenditure targets would be implemented. The ACS expenditure target proposal does, however, raise two policy issues that the Congress needs to consider carefully. First, if expenditure targets are to move beyond the national level, is it most appropriate to establish them at the specialty level (as suggested by ACS) or at a geographic level (as suggested by PPRC)? Second, if expenditure targets are to be established, is the type of phasing schedule advocated by ACS appropriate, with development of data and targets first, and the targets phased into the payment system in later years?

Conclusion

AARP continues to support the goals of physician payment reform, and ask you to consider seven key points as you develop your proposals.

First, we begin with the premise that the purpose of Medicare is to provide beneficiaries financial protection for access to needed health services. Payments to physicians are a means for achieving that objective. The Congress must evaluate its proposals against that objective.

Second, any change in payment rates such as those arising from an RBRVS, even if budget neutral in the aggregate, means that some beneficiaries would pay more in coinsurance for some important services or in some places -- generally the very

services an RBRVS proposes to encourage -- and less for others. The Congress cannot ignore the fact that while a payment reform proposal may be budget neutral in the aggregate it will not likely be budget neutral for the individual beneficiary. Further information on the distribution and characteristics of the "winners" and "losers" is essential before action is taken.

Third, AARP recognizes volume as a key issue. However, no clear cut solution appears on the horizon. The Association believes it is necessary to pursue continuing research and development of practice guidelines. These guidelines, once established, should be incorporated into the payment system before expenditure targets are considered further. PPRC proposals for a national expenditure target requires greater elaboration but holds promise.

Fourth, monitoring volume, access to care and impact on beneficiaries is crucial to any reformed system, and might best be preceeded by explicit statements of Congressional goals in these areas. This information will be vital to see if the system achives the results intended, and to provide information that would be useful to refine the payment system over time.

Fifth, any changes in the payment system should be implemented in phases over a transition period of five or more years. That is important to minimize problems arising from sharp changes in beneficiary payments and providers fees. In addition, it would provide time to evaluate the impact of the initial changes and refine the system as we proceed.

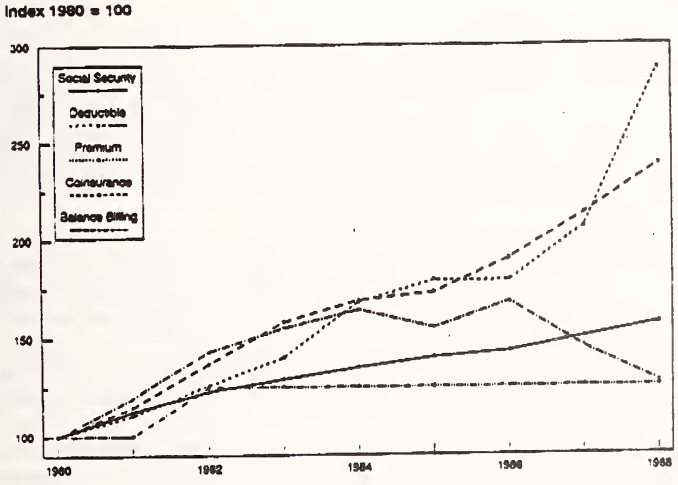
Sixth, the major out-of-pocket spending increases by beneficiaries now arise from the beneficiaries' significant

contribution for deductibles, coinsurance, and premiums -- increases which stem directly from the escalating cost of Part B of Medicare. Assuming continuing and enhanced protections from extra billing we would want payment reform to provide a vehicle for reduction in the rate of increase in both government and beneficiary spending.

Finally we would urge the Congress to maintain the policy of assuring that payment changes be accompanied by beneficiary financial protection from extra billings. This includes mandatory assignment once fair fees are achieved through reform.

AARP thanks the Subcommittee for this opportunity to appear today to discuss this important issue, and I would be pleased to answer any questions that you may have.

Figure 1-5. Trends in Social Security Benefits and Part B Out-Of-Pocket Costs, 1980 - 1988



Source: Congressional Budget Office and Health Care Financing Administration.

Mr. WAXMAN. Thank you very much, Mr. Amsden.

I understand your point that if we raise and lower Medicare payments, the beneficiaries' coinsurance is also going to go up and down; some will pay more for services now received. However, I can't tell whether you're saying that is of sufficient concern that we should not proceed with payment reform.

Right now, beneficiaries in different parts of the country are paying different amounts out of pocket for the same service because of unwarranted variations in physicians fees. Shouldn't we be concerned about improving the equity of that situation?

Mr. AMSDEN. We should be interested in improving the equity, yes, and we should move forward. Under a system that may be devised, all I was merely trying to point out is that, from today's standard to tomorrow's standard, there may be some beneficiaries who will see some individual loss.

Mr. WAXMAN. Would you support an approach similar to that recommended by the PPRC, under which the RBRVS would be used initially to make marginal changes in the current fees, and with full implementation taking place over several years?

Mr. AMSDEN. I'm going to suggest that—I have two representatives here from the organization, and I think that they themselves would be far better qualified to speak to that specific detail than I would.

Mr. WAXMAN. Do you want to come forward now or submit it for the record?

Mr. AMSDEN. They will submit it for the record.

Mr. WAXMAN. Okay. We will look forward to getting that for the record.

Mr. AMSDEN. Okay.

Mr. WAXMAN. Mr. Bruce.

Mr. BRUCE. First of all, I would like to thank your organization for your support of the catastrophic insurance program and the heat you have taken. None of my constituents have written me about it, but other members have told me that they received mail about it. As a member of the subcommittee, I didn't have anything to do with it.

That's what I tell them back in Illinois.

In your testimony you indicated you object to the 25 percent participation suggested by President Bush. Do you have any figure that you're comfortable with? If you're not going to pay 25 percent of the costs, where do we go?

Mr. AMSDEN. No, I don't have any figure that I would be comfortable with. Again, I would defer to the staff on that specific question.

Mr. BRUCE. I don't want you to have a bad headline, so I won't pursue that. I just wondered if your organization had taken a position on that.

Mr. AMSDEN. No. As a matter of fact, the organization board of directors is still reviewing their position on this issue.

Mr. BRUCE. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much for your presentation.

Mr. AMSDEN. Thank you.

Mr. WAXMAN. We look forward to working with you.

I would now like to call forward the following people to testify: Dr. Joseph F. Boyle, executive vice president, American Society of Internal Medicine, who will be accompanied by James Nuckolls, M.D., president of the American Society of Internal Medicine; Dr. Paul Ebert, executive director, American College of Surgeons; Dr. Lee Rogers, chairman of the board of chancellors, American College of Radiology, accompanied by Dr. James Moorefield, vice chairman of the board of chancellors, American College of Radiology; Dr. Michael D. Bishop, chairman of the physician payment committee of the American College of Emergency Physicians; and Dr. H. Logan Holtgrewe, treasurer of the American Urological Association.

If you would all come forward, please. We are pleased to have all of you here. We will have your complete statements in the record, but we are limited, unfortunately, because of time constraints, to no more than 5 minutes for the oral presentations.

Dr. Boyle, why don't we start with you.

STATEMENTS OF JOSEPH F. BOYLE, EXECUTIVE VICE PRESIDENT, AMERICAN SOCIETY OF INTERNAL MEDICINE; PAUL A. EBERT, EXECUTIVE DIRECTOR, AMERICAN COLLEGE OF SURGEONS; LEE ROGERS, CHAIRMAN, BOARD OF CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY, ACCOMPANIED BY JAMES MOOREFIELD, VICE CHAIRMAN; MICHAEL D. BISHOP, CHAIRMAN, PHYSICIAN PAYMENT COMMITTEE, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; AND H. LOGAN HOLTGREWE, TREASURER, AMERICAN UROLOGICAL ASSOCIATION

Mr. BOYLE. Good morning, Mr. Chairman, Mr. Bruce.

I am Joseph F. Boyle, executive vice president of the American Society of Internal Medicine. With me today is Dr. James Nuckolls, President of the American Society of Internal Medicine, an internist in private practice in Galax, VA.

We have provided the subcommittee with a full report on our opinions of the various recommendations of the PPRC, in addition to which we have provided some recommendations as to how the committee might proceed now in meeting some of your budget obligations. I will not discuss any of those this morning, other than some comments on the RBRVS.

I think it is important for us in the medical community to keep in mind why the RBRVS was created in the first place. The Congress mandated the development of the RBRVS because it recognized that Medicare's so-called customary, prevailing and reasonable charge system method of determining Medicare payments for physician services no longer made any sense. The subcommittee did that several years ago and nothing has changed in the interim that would alter that view.

Physicians fees in the past always were, and today are, influenced by the unequal payments that have been made traditionally in the past, first by insurance companies and later by Medicare and other third parties. As they have become involved in this, the present system has inherited all of the distortions and inequities of the values placed on physicians' services and those have been magnified over time.

Most health insurers either did not cover cognitive services, such as office visits or medical and surgical consultations, or covered them only when the patient paid a high deductible or was an inpatient in the hospital. Because the fees for evaluation and management services would be paid out of pocket, these traditionally were maintained at a relatively low level. Similarly, people in rural areas were charged lower fees, and that has been maintained to the present as compared to urban areas.

The problem with all of these inequities and distortions in the Medicare program is that the wrong signals were being sent to everybody—sent to physicians, sent to society, sent to individual patients; that is, that spending time with a patient in the physician's office in evaluating a complex medical problem simply was not worth that much. The same signal has been given to medical students and physicians in training. It is said that if you locate your practice in a metropolitan area, its value is greater than if you locate in a rural community.

CPR in the process also has been inflationary, since Medicare payments automatically increased as physicians raised their fees. For the Congress, because of annual budget problems and a steady increase in costs, the Congress each year has been forced to respond by capping prevailing charges, freezing fees, selective payment rollbacks, and selective cuts here and there, frequently without necessarily having objective methods of measuring what was being done.

The Congress responded to all of these inequities and continuing problems by directing that there be developed a method to provide for a fee schedule based upon resource costs. This has been reported. PPRC has reported both to HCFA and to the Congress—Dr. Lee reported at length this morning. PPRC believes that the Harvard RBRVS is a fundamentally sound approach to determining relative values and, with a few refinements, can be used as early as next year to create an interim RBRVS Medicare fee schedule. ASIM strongly supports this conclusion.

The second question is, who will benefit from an RBRVS fee schedule. We believe that all of those involved will benefit. We believe that patients will benefit because there will be in place a more rational, predictable system, and a system which will encourage the use of those kinds of services which patients seem to want and need. We believe that it will provide an extraordinary advantage to the Congress, that Congress will no longer have to become involved in this annual dispute over which services are worth more, and we believe that despite the grumbling or understandable disagreements by some segments of the medical profession, that our profession also stands to benefit from the development of an RBRVS.

This brings me to a final question, and that is, why should you act now. Given the fact that you have a proposal which offers significant benefits for the public, there is no good reason not to act right now. As a matter of fact, Mr. Chairman, if I could put it in a different kind of context, each year now, for at least the last 5 years, the Congress has been asked in your budget reconciliation discussions to consider just how physician payments ought to be treated, at what level and in what form. At the same time, there is

a long list of other issues that remain to be addressed. Those issues concern establishing rational practice guidelines. We applaud your efforts in this arena, Mr. Chairman.

The question of how we're going to deal with those underinsured and uninsured, how we should expand Medicaid, how we should rationalize some other segments of the entire health care system in this country, this is one small segment which we believe can be decided and put over here. Once it is determined that this is the way it's going to be done, we can all get on with trying to address a much larger agenda of probably far greater importance.

[Testimony resumes on p. 171.]

[The prepared statement of Mr. Boyle follows:]

STATEMENT

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

My name is Joseph F. Boyle, MD, Executive Vice President of the American Society of Internal Medicine (ASIM). I appreciate the opportunity to express the views of internists and internists-subspecialists nationwide on reform of the Medicare system of payment for physician services, with particular attention to the proposals just released by the Physician Payment Review Commission (PPRC).

Before explaining in detail ASIM's views on payment reform based on a resource based relative value scale (RBRVS), as recommended by the PPRC, we believe that it is important to address several key questions that are at the heart of the current debate.

First, why was the RBRVS created in the first place? With all of the discussion you'll inevitably hear today about some highly technical issues relating to the RBRVS, its important to get back to basics and discuss why Congress mandated development of the RBRVS in the first place. Congress did so because it recognized that Medicare's so-called "customary, prevailing, and reasonable" charge (also known as CPR) method for determining Medicare payments for physician services no longer made sense.

Under CPR, Medicare payments roughly approximated what physicians' charged for their services, at least at first. But since physicians' fees were (and are today) influenced by unequal insurance coverage for different kinds of services, the Medicare program inherited distortions and inequities in the value placed on physician services.

Because most health insurers provided good benefits for surgery, in-hospital care, and diagnostic tests, physicians charged more for those services--not because of greed, but because those services were "covered by insurance" and therefore would not represent

big out-of-pocket expenses to patients. By comparison, most health insurers either did not cover such cognitive services as office visits or medical or surgical consultations, or covered them only after the patient paid a high deductible. Because fees for evaluation and management services would be paid out-of-pocket by their patients, physicians kept fees for these services artificially low. Similarly, because people in rural areas were less likely to have access to health insurance, fees in rural areas tended to be much lower than in urban communities.

The problem with all of this is that by inheriting these inequities and distortions, Medicare's CPR system sent all the wrong signals to physicians. It said that doing a procedure would be valued more for the work involved than spending time with a patient in your office evaluating a complex medical problem. It said that practicing in specialties that do procedures would be valued more than providing primary care services. It said that locating your practice in metropolitan areas would be valued more than practicing in rural communities. It said that if you performed procedures you would be paid well, but if you offered primarily evaluation and services, you would not be.

CPR was also inflationary, since Medicare payments increased automatically as physicians raised their fees. Faced with annual increases that Congress concluded were in excess of that needed to keep pace with rising practice costs, Congress responded each year by capping prevailing charges, freezing fees, and selectively rolling back payments for certain services. As a result, we ended up with is a system that is extraordinarily complex, unpredictable and difficult to administer, but one that still fails to link Medicare payments to any rational measure of what constitutes a reasonable fee for a service.

Fortunately, however, Congress responded to the problems and inequities inherent in the CPR system by mandating investigation of a new way of paying for physician services. Rather than accepting that just because insurers historically provided better benefits for certain services, those services are automatically more valuable than other services, Congress instead directed PPRC and HHS to investigate the idea of basing payments on resource costs. A resource based relative value scale, or RBRVS, values physician services based on the work or resources required to provide each service. Services that require more time, judgment, risk, effort, and direct costs are valued more than services that require less work. Once an RBRVS is created, a Medicare fee schedule could be developed simply by multiplying those relative values by a uniform dollar multiplier.

Under contract with HHS, Harvard University has completed the first phase of a research effort to develop an RBRVS for Medicare, and will shortly be completing the final phase of that project. The PPRC believes that the Harvard RBRVS is a fundamentally sound approach to determining relative values, and with a few refinements, can be used as early as next year to create an interim RBRVS Medicare fee schedule.

As explained in detail later in our testimony, ASIM strongly supports this conclusion. For Congress, though, your actions are likely to be determined largely by the answer to a second question that is key to this debate: who benefits from an RBRVS fee schedule?

In our view Medicare patients will benefit the most from a more rational system of payment. But ASIM also believes that the medical profession and Congress are also well-served by an RBRVS payment system.

Patients will benefit because under an RBRVS, surgical and technological procedures no longer will be paid more for the work involved than evaluation and management

services. Instead of being penalized for spending time with patients providing evaluation and management services, physicians will for the first time be appropriately compensated for those extraordinarily important cognitive services. Physicians will be able to make patient care decisions based solely on what is best for the individual patient, without being influenced by disproportionately higher payments for the work involved in some services compared to others. Physicians entering practice will no longer be as influenced by disproportionately high or low payments for services associated with different specialties, or different parts of the country, in making decisions on what specialty they enter or where they choose to practice. And patients will benefit from a system that will be far less complex and more predictable than CPR.

Congress will benefit by putting in place a rational and fair long-term approach to determining Medicare payments, instead of being forced year after year to make arbitrary cuts in Part B payments. I think that you would agree that it is far better to have a system in place that offers a rational way to establish reasonable fees for each service covered by Medicare, rather than asking Congress to take a shot in the dark each year in deciding what services to cut, or to increase, and by how much.

Despite some understandable disagreements by some within the the medical profession, our profession also stands to benefit from the RBRVS. Implementation of an RBRVS will assure that as Congress deals with future Medicare budgets, all specialties can be assured of equal treatment. It will also allow for greater unity in the future in meeting the challenges of such critical issues as assuring access to care for the poor and uninsured.

Which brings us to our final question: Why should Congress act now to mandate RBRVS implementation? Given the fact that you now have before you a proposal that offers

significant benefits for the public, there simply is no good reason not to act. With the PPRC being in a position to work with Harvard on refining the technical issues that remain, there will be an ongoing opportunity for all affected groups to raise whatever methodological issues they wish with the Commission. But I doubt that Congress wishes to be the ones to make such purely technical judgments. Your commission has presented you with a basic policy decision: whether the country is better served by continuing the CPR system or mandating an RBRVS fee schedule. They have assured you that the RBRVS is sound. They have provided you with the information needed to enact reform legislation this year. They have offered a suggested timetable for implementation. They have developed a process for further input and refinement.

But only you can make the basic policy decision that is required to bring about implementation of an RBRVS payment system. We urge you to do so, and to do it now.

With that introduction, I am pleased to elaborate on ASIM's views on the elements that should be included in a comprehensive reform package.

ELEMENTS OF COMPREHENSIVE REFORM

ASIM believes that an effective, comprehensive, and long-term approach for payment reform should consist of the following elements:

1. **Implementation of a fee schedule based on the Harvard resource based relative value scale (RBRVS), as called for by the Physician Payment Review Commission.**

The PPRC has called on Congress to enact legislation this year to mandate a Medicare fee schedule based on the RBRVS being completed by Harvard University, with partial

implementation taking place within six months of enactment, and full implementation over two years. Geographic differentials in payment would be limited to differences in the costs of providing services. The RBRVS would for the first time link Medicare payments with the work or resources (time, mental and physical effort, judgment, and overhead) required to provide physician services.

ASIM is particularly pleased that the PPRC, following an extensive review of the methodology and raw data collected in the Harvard study, consultation with outside experts, and testimony by numerous physician organizations, has concluded that the basic methodology of the Harvard RBRVS is sound. Further, ASIM agrees with the Commission that the estimates of physician time and effort developed by Harvard should be used as the initial basis for that component of the RBRVS in a new Medicare fee schedule. Although the PPRC has identified areas where it and Harvard are undertaking further refinements, it is extremely significant that the Commission has rejected the views of those who argue that the RBRVS is inherently "flawed", or that sufficient refinements cannot be made within the next several months in order to permit implementation as early as April, 1990.

It is also important to recognize that the Harvard RBRVS, and the recommendations of the Commission, reflect Congress' own interest in establishing a more rational basis for determining physician payments that based on the resource costs of providing those services. Both the Omnibus Budget Reconciliation Acts of 1985 and 1986, which mandated the development of an RVS based on resource costs, expressed this desire. Congress should now move forward and enact legislation, as recommended by the PPRC, to mandate that implementation of a fee schedule based on the RBRVS begin in April 1990, with full implementation taking place within two years.

The Commission is also recommending that the Medicare fee schedule determine payments to all physicians, including those already paid under separate fee schedules. ASIM strongly supports this recommendation. As the Committee is aware, OBRA 1987 mandated implementation of separate fee schedules for anesthesia services and the services provided by radiologists, and called on the Secretary of HHS to develop a proposal for a fee schedule for pathology. ASIM strongly agrees with the PPRC that these efforts should be incorporated into a uniform RBRVS fee schedule for all physician services.

ASIM strongly believes that it would be inconsistent with the PPRC's recommendation for Congress to require establishment of additional separate fee schedules for subsets of physician services, such as surgical procedures. As this committee is aware, the American College of Surgeons (ACS) has proposed a separate fee schedule for surgery only. Under this proposal, the surgical fee schedule would be established at a budget neutral level. This proposal ignores one of the major advantages of establishing a uniform fee schedule based on the Harvard RBRVS: the ability to make comparisons on the relative work of physicians both between and within specialties. Without being able to make such comparisons, it is impossible to correct distortions in the existing pricing system that now favor technological procedures over evaluation and management services. Simply reallocating resources within surgery by partial use of resource costs would in no way correct the disparity in reimbursement between physicians' evaluation and management (or cognitive) services and technological procedures.

Moreover, a budget neutral target for surgical services would preclude any increase for evaluation and management services, thus eliminating the advantages that would accrue to the medical care system from improved reimbursement for those historically undervalued services. Separate fee schedules are also far more confusing and complex to administer than a uniform, inclusive RBRVS fee schedule that applies the same rules of payment to all services by all physicians, regardless of specialty. We believe that

whatever Congress decides should be done with the physician payment system, all physicians, in all specialties, should be wiling to play by the same rules.

On other issues relating to the Commission's recommendations on an RBRVS fee schedule, ASIM:

- Supports incorporating average time descriptors in CPT-4 codes for visit services. ASIM agrees with the PPRC's conclusion that this approach will be far more effective in eliminating potential miscoding of services than "collapsing" CPT-4 visit codes. Consequently, we urge Congress to act favorably on the Commission's recommendation to delay the OBRA 87 mandate to HHS to "collapse" such codes.

- Supports establishing the initial dollar conversion factor at a budget neutral level.

- Supports limiting variations in payment levels by region only to actual differences in the cost of providing services (overhead). As discussed later, this will significantly improve access to physician services in underserved rural and inner city communities.

2. **Establishment of a "safety net" to protect low-income beneficiaries from out-of-pocket expenses that they cannot afford.**

Although ASIM believes that beneficiaries are best served by a policy that enables them to contract with physicians who may bring to their care more experience, training, or expertise than the norm--and who therefore charge an appropriately higher fee than that allowed by a fee schedule--it is appropriate to provide special protection for low-income

beneficiaries. Consequently, as part of comprehensive reform of physician payment, ASIM supports appropriate limits on balance billing to low-income beneficiaries. The PPRC's proposal to require acceptance of assignment for all individuals whose Medicare cost-sharing must, by law, be paid by their respective states (i.e., all those whose incomes are below the U.S. poverty level) is consistent with this principle.

ASIM strongly believes, however, that it is inappropriate and unnecessary to establish an overall limit on charges to all beneficiaries at some percentile level above the payment levels established by the fee schedule, as the Commission has recommended. Such a requirement, in ASIM's view, is a prescription for mediocrity. It is well recognized that in every field--including engineering, law, architecture and accounting--there are some individuals that have more experience, greater expertise, and offer a better service than the norm for their field. Those individuals typically and appropriately charge more for their services than the average. This is as true in medicine as it is in any other field of endeavor. Patients should have the right to select physicians who bring greater skill to treating their individual problems, and who therefore have an appropriately higher charge. Limiting all physician fees to some pre-determined percentile above the RBRVS fee schedule would preclude that choice. It would also act as an discentive for physicians to obtain additional skills and training, since there would be no additional compensation to recoup the cost of such training. Any fee schedule, even one based on resource costs, by its nature represents a standard or average; balance billing is the only way to recognize differences in the skill and training of individual physicians, and in the needs and desires of individual patients.

3. **Expansion of policies designed to develop the scientific knowledge--and the means--to assure that only effective services are reimbursed by the Medicare program.**

ASIM has previously provided Congress with a paper titled "Controlling the Volume of Ineffective Medical Services: A Plan of Action" that included 14 specific recommendations on the volume issue. The recommendations include increasing medical review of services provided in organized outpatient settings; substantially increasing the resources devoted toward developing practice guidelines, particularly for high volume procedures; studying ways to bundle certain physician services; increasing data collection and analysis; and instituting measures to improve the effectiveness of medical review. ASIM strongly supports the PPRC's proposals for a significant expansion of funding for effectiveness research and the development of practice guidelines.

We urge Congress, however, to proceed cautiously before mandating measures that could diminish access and quality of care, such as the PPRC's recommendation for national expenditure targets. ASIM agrees with the esteemed chairman of this subcommittee, the Honorable Henry Waxman, who recently stated in testimony before the House Budget Committee that "We must proceed cautiously in seeking to reduce the growth in the volume . . . of services furnished under Medicare. The best strategy, in my view, is to invest some money where it will contribute to a better understanding of the effectiveness of services and better tools for eliminating inappropriate care."

Unlike the Commission's recommendation on the RBRVS fee schedule, which reflects over ten years of debate and evaluation, and two and one-half years of intensive work on the part of the PPRC, the expenditure target proposal has not undergone critical scrutiny. This concept has not been the primary focus of the Commission's hearings and work over the past several years. Consequently, the Commission has not had the benefit of the same type and degree of expert advice, public comment, and research that were reflected in its recommendation on the RBRVS fee schedule. This is unfortunate,

particularly given the fact that the expenditure target approach could have even greater ramifications for the quality and accessibility of medical care in this country than a fee schedule.

The purpose of the expenditure target approach is to limit services provided to Medicare beneficiaries. As such, it must be recognized as a form of rationing. According to the dictionary, "ration" means to restrict to limited amounts. The Commission acknowledged in its March 1988 report to Congress that "the intent of expenditure targets is to make explicit to physicians the limits of the resources society has decided to make available for health care..."

Presumably, the Commission intends for only "unnecessary" or "ineffective" services to be eliminated. Given the lack of data and consensus on the effectiveness of different medical services and procedures--and the inherent contradiction in attempting to set a limit on overall expenditures without any public consensus of how much *should* be spent on medical care--it takes a large and unjustified leap of faith to presume that only "waste" will be cut from the system.

Put into individual terms, expenditure targets can only work if individual doctors decline to provide certain services to their patients that they otherwise would have provided. *Without a scientific basis for making such a determination, however, it is just as likely that "effective" as "ineffective" services will be denied, particularly in grey areas where there is no clear consensus on what is the best way of treating a particular problem.* Consequently, it is the patient, not the physician, that is at risk under the expenditure target concept. This distorts the physician's traditional role as advocate of his or her patient, by placing the physician in the position of limiting services to patients in order to meet predetermined targets established by the federal government.

It is also unclear how the medical profession can collectively control utilization across

the country in order to meet the expenditure target. An individual physician who practices a conservative style of medicine would still be financially penalized if overall expenditures exceed the expenditure target limit. Similarly, lower cost regions of the country will be at risk for higher utilization in other parts of the nation. Physicians in one specialty will similarly be at risk if physicians in other specialties increase their volume of services. Consequently, expenditure targets place individual physicians at risk for behavior by their colleagues that is outside their own control. Moreover, there is no organized system of utilization review now in place nationwide that would enable the profession to collectively control the volume of services.

What is needed instead is the development of the data and scientific basis needed to establish guidelines for evaluating the effectiveness of different medical and surgical interventions. A strategy designed to obtain the knowledge--and the means--for reviewing and evaluating the effectiveness of different ways of treating patients offers far more potential than expenditure targets for appropriately controlling the volume of ineffective medical services, without compromising patient care. By developing guidelines first for high volume procedures where it may be relatively easier to obtain a consensus on effectiveness, it is likely that the Medicare program can begin saving significant amounts of money in the relatively near future — without resorting to the imposition of expenditure targets. ASIM strongly supports the efforts of Mr. Waxman to develop a legislative proposal to stimulate the development of effective practice guidelines, and looks forward to working further with you in the development of this proposal.

4. Enactment of interim measures for FY 1990 that are consistent with long-term reform based on RBRVS.

ASIM recognizes that Congress has an immediate interest in moderating Part B

expenditures as part of FY 1990 deficit reduction. Consequently, we would support appropriate measures to reduce spending, provided that they are fair, reasonable, and not in conflict with the objectives of long-term reform. Capping prevailing charges for radiological, anesthesia, and surgical (RAS) services, after adjustment for cost of practice, at some percentile above the national mean (e.g. 120th percentile), and increasing the existing floor (now set at the 50th percentile of the national mean) for primary care services, could achieve FY 1990 savings in a way that is consistent with long-term reform based on the RBRVS. It would also be far more fair than the across-the-board cuts in RAS services proposed in the President's budget, since it would reduce payment for RAS services only in those areas that are now reimbursed well in excess of what can be explained or justified simply on the basis of higher practice costs.

According to PPRC, an RBRVS fee schedule with geographic multipliers based on cost of practice would in general decrease reimbursement for RAS services provided in large metropolitan areas, and increase payments for primary care services in smaller metropolitan and rural areas. Establishing a cap on prevailings for RAS services, and increasing the floor on prevailings for primary care, would therefore simulate the effects of the RBRVS by targeting those services that are most likely to be increased or decreased once the fee schedule is implemented. Preliminary estimates by CBO and PPRC on variations of this proposal (e.g., capping prevailing charges for all Part B physician services and raising the floor for primary care only) suggest that such an approach might bring about substantial FY 1990 savings, although the specific option of capping only charges for RAS services has not yet been assessed. ASIM also believes that primary care services not subject to the new floor on prevailing charges should receive the full Medicare economic index (MEI) update.

ASIM cautions Congress, however, to consider the magnitude of cuts that have already taken place in Medicare Part B before deciding on the extent of further cuts. In

addition, ASIM strongly believes that no portion of Medicare should be considered to be off-limits, and that Congress should consider appropriate increases in revenue--such as an increase in so-called "sin" taxes--in its efforts to achieve deficit reduction.

IMPACT ON ACCESS, QUALITY, OUT-OF-POCKET EXPENSES, COSTS, AND VOLUME

ASIM believes that this comprehensive approach to payment reform will have a favorable impact on several objectives that Congress, the medical profession, the Physician Payment Review Commission, and others agree should be driving long-term reform.

Improving Access and Quality

By substantially improving payments for undervalued primary care services, particularly in rural communities, payment reform with an RBRVS fee schedule at its core will correct distortions that now act as a barrier to provision of these services in underserved areas. The interim measures proposed above (capping prevailing charges for RAS services and raising the floor on payments for primary care) will also help move the system in the appropriate direction.

An RBRVS fee schedule, by neutralizing incentives that favor one type of care over another, will also enhance quality. For the first time, physicians will not be biased by higher payments for the work involved for some services compared to others in making decisions on how to best treat their patients. Consequently, this plan represents an important step in assuring that physicians' decisions are based solely on what is best for their patients, rather than on which services are more financially rewarding for the work involved. Since the amount of time a physician spends with patients correlates closely with quality of care and patient satisfaction, the RBRVS--by no longer penalizing physicians for time-consuming cognitive services--will also enhance the overall quality of

physician-patient encounters.

Protecting Beneficiaries from Excessive Out-of-Pocket Expenses

Establishing limits on balance billing to low-income beneficiaries will protect those who cannot afford to pay more than the Medicare-approved amount under a fee schedule, while maintaining the basic right of beneficiaries to choose and contract with any physician of their choice, including physicians with special expertise who may charge relatively higher fees. RBRVS-based reform will also improve overall acceptance of assignment, particularly for undervalued evaluation and management services.

Patients' financial contributions to surgical care will also be substantially reduced. Based on preliminary simulations by PPRC, the reduction in Medicare's approved amount for coronary bypass surgery under an RBRVS fee schedule from $3,894 to $2,610 would *decrease* co-insurance (the amount the beneficiary must pay) by $256 ($778 to $522). Even though co-insurance for evaluation and management services would increase nominally (co-insurance for an intermediate office visit would increase by only $1.41, for example), this would be more than made up by increased acceptance of assignment for those services and the savings in co-insurance for surgery. For example, it would take 181 intermediate office visits at the slightly higher co-insurance level under the RBRVS to cancel out the savings that a patient who undergoes bypass surgery would receive through reduced co-insurance for just that one procedure. The majority of beneficiaries with Medigap insurance would also be protected from increases in coinsurance for any services.

Making Expenditures More Moderate and Predictable

Although implementing the RBRVS fee schedule in a budget neutral manner--as

recommended by PPRC--will not by itself reduce expenditures, the impact on the budget of future increases in payment rates will be far more predictable than under the existing "customary, prevailing and reasonable" charge system. By tying future increases in the conversion factor to a reasonable measure of inflation, Congress can assure that price increases do not exceed that which is necessary to maintain the same level of service to beneficiaries. In addition, by neutralizing incentives that may encourage excessive reliance on certain technological services, overall costs can be expected to moderate in the long run. As long as invasive procedures are paid more for the work involved than other services, there will be an inherent bias toward doing more technological procedures--a bias that conflicts with any strategy designed to get increases in volume under control. Development of practice guidelines can also achieve future cost-savings, particularly if developed first for those services that have experienced the greatest increases in volume, such as diagnostic and surgical procedures. The proposal for capping prevailing charges for RAS services would also bring about immediate FY 1990 savings in a way that is consistent with RBRVS based reform.

Summary and Conclusions

In conclusion, ASIM strongly urges Congress to establish policies this year that would begin moving the physician payment system toward rational, long-term reform. At a minimum, such policies should include:

- A clear mandate to implement an RBRVS fee schedule beginning in 1990. Such a fee schedule should incorporate all physician services, regardless of specialty.

- Limits on balance billing for "low-income" individuals, while maintaining the basic right of beneficiaries to contract with the physician of their choice, including physicians' who charge more than the average (or some percentile

above the average) under the fee schedule.

- Attainment of immediate FY 1990 budget savings in a way that is consistent with long-term RBRVS based reform, such as by capping prevailing charges for RAS services and raising the existing floor on prevailing charges for primary care services.

- Expansion of policies to develop the knowledge to determine the effectiveness of different services. The Patient Outcomes Research bill, introduced by Reps. Stark and Gradison, represents a significant step forward in developing the knowledge needed to control the volume of ineffective services. ASIM commends Reps. Stark and Gradison for this initiative. Congress must exercise appropriate caution, however, before enacting legislation to establish national expenditure targets, which may have uncertain--and quite possibly detrimental--effects on the quality and accessibility of medical care.

ASIM stands ready to assist Congress in any way possible in bringing about comprehensive reform based on these principles.

Mr. WAXMAN. Thank you very much.
Dr. Ebert.

STATEMENT OF PAUL A. EBERT

Mr. EBERT. Thank you, Mr. Chairman. I am Paul Ebert, from the American College of Surgeons. I would just like to emphasize a few points of our proposal that you have in writing.

We agree and do think that serious steps need to be taken by Congress to moderate spending for the Medicare program. We also think it needs to be a more comprehensive plan to balance the fee considerations, increases in volume of services, and the intensity of the services provided to patients.

I think you are aware that our plan has really four components, and that is to make Medicare expenditures—and I emphasize—for surgical services more predictable for both surgeons, beneficiaries and the government, based on development of criteria for addressing the volume of services and phased implementation of a target expenditure program.

Now, proposals need to be done for improving the financial protection of Medicare beneficiaries, and we do believe that there needs to be fundamental changes in the assignment program, especially for those in the lower-income bracket.

There needs to be implementation of a what we would prefer, a blended fee schedule, because we have not been of the belief that the RBRVS covers the important and total aspects of reimbursement. And the timetable could be long or short, depending on how the program was specified.

Now, I would like to just talk for a moment about expenditure targets, because I think we're hearing today that you have a budget process that essentially is an expenditure target, whether you like it or not. It's a retrospective expenditure target. You come forth each year with a budget. A certain amount is reduced after a certain amount is put in for cost of practice or living. Having seen the surgical services of the majority of years, we're usually the beneficiaries of most of the reductions of that particular program. So we feel that what's wrong with having a target out in the foreground that both the government, the beneficiary, and the medical community could have input into, and thus, we would realize at that point whether a year from now we were within or without the limits of that target.

Now, you heard talk a lot this morning about guidelines for surgical practice. The majority of guidelines currently employed are for inpatient hospital services. There is very little available for office-based physicians or the office-based component of a surgical practice. So we think it is very easy to assemble the infrastructure within a surgical community to implement guidelines in a more plausible fashion. We don't believe they should be punitive and limiting of services.

I agree with the comments made before, that today they really are two separate issues. They are not really an incentive to do less by any means whatsoever.

We also have a system today that the majority of access to the system from the Medicare beneficiary does not seem to be a major,

serious problem. We see over 50 percent of surgeons accept assignment, and we also see that in the dollar output, over 80 percent of the dollars spent by the Medicare program are to physicians and surgeons who accept assignment.

I would only like to conclude with a comment on the financial incentive to go into various aspects of medicine. There really is no increase in the number of surgeons in training today as compared to 10 years ago. In fact, there is even a reduction. Thus, if it was financial incentives only that is causing individuals to choose various locations in the country, or various portions of their specialty, it doesn't seem to us to be borne out by the data. By GEMENAC projections, surgery is 26 percent below what GEMENAC projected it would be for 1990. Thus, I really don't believe that's a very compelling argument to support the concept that it's financial reimbursement.

We also are constantly hearing the word "overpriced" procedures. The question often is are they overpriced in relation to what. I suppose if the Medicare fee schedules across the country are compared to a Medicaid type of fee schedule, then they're overpriced. If they're compared to private insurance, they are probably not. Thus, I would be happy to address any of the more specific aspects of the written proposal.

Thank you.

[Testimony resumes on p. 190.]

[The prepared statement of Mr. Ebert follows:]

STATEMENT

of the

AMERICAN COLLEGE OF SURGEONS

to the

Subcommittee on Health and the Environment

Energy and Commerce Committee

U.S. House of Representatives

Presented by

Paul A. Ebert, MD, FACS

RE: Proposals to Modify Medicare's Physician Payment System

May 25, 1989

Mr. Chairman and members of the Committee, I am Paul A. Ebert, MD, FACS, the Director of the American College of Surgeons. The College appreciates once again the opportunity to present its views on Medicare physician payment issues.

Mr. Chairman, the College and representatives of the major surgical specialty societies have completed a thorough reexamination and assessment of many of the payment policy concerns that this Committee will be addressing. We wish to take this opportunity to put before you a comprehensive set of new proposals for dealing with a number of major payment reform questions, including the problem of expenditure control. The elements of our plan are focused principally on the quality, volume, and cost of surgical services provided to Medicare patients, although we believe that features of the plan could have broader application. Equally important, we believe that new Medicare beneficiary

protections should be added to the program during implementation of this plan.

In brief, this plan consists of the following complementary elements:

1. A plan to moderate the growth in Medicare outlays for surgical services by addressing the issue of volume and to make those expenditures more predictable for beneficiaries and the government;

2. A set of proposals for improving the financial protection of Medicare patients through fundamental changes in the assignment program;

3. The development of a new, blended Medicare fee schedule for surgical services that reflects both improved measurements of supply-side, or resource cost inputs, with important demand-side considerations, including the efficacy and relative benefits of treatments as seen by both physicians and patients; and

4. An explicit timetable for phased implementation of the proposed changes.

Mr. Chairman, at the heart of our new comprehensive plan is a public commitment from the American College of Surgeons, the surgical specialty societies, and their more than 85,000 members, to work directly with the beneficiary community--and we hope with the Congress--to reach an agreement on a broad range of physician payment goals that can be implemented in an orderly manner.

As you know, the Physician Payment Review Commission (PPRC) recently submitted its 1989 annual report. We were pleased to learn that some of the concepts that have been proposed by the

College also were included in the recommendations made by the PPRC.

THE VOLUME ISSUE--PLAN FOR MODERATING EXPENDITURE GROWTH

Mr. Chairman, if serious steps are to be taken to moderate spending for Medicare services, including the services of surgeons, then some workable approach must be found to strike a better balance among fee considerations, increases in volume and intensity, and the financial protections afforded beneficiaries under the program. This, it seems to us, is far more important than focusing attention almost exclusively on how payments should be distributed among different categories of physicians.

If we are going to be realistic, Congress must recognize that spending for health care probably will continue to rise, even if all hospital and physician payments were to be frozen at today's price levels. After all, the total number of Medicare beneficiaries is increasing every year, and the average age of the older population in this country also is rising, so that the demand for medical attention from the elderly can only be expected to increase as well. Moreover, changing medical technologies, better diagnostic techniques, and improvements that enhance the quality of life for older patients also contribute to increased Medicare spending for health services, and few would suggest that the aged--but not the young--should forgo these benefits. The major policy problems for the Congress, as we see it, are to determine by how much spending growth can be moderated without serious consequences for aged patients and whether such costs can be made more predictable.

Up to now, two general methods for reducing health spending have been discussed--either reducing the unit prices (or fees) of physicians' services or reducing the volume of those services.

The volume of physicians' services obviously reflects judgments about medical necessity that are influenced by the state of medical knowledge, and also, in part, by the professional liability climate. We believe that more physician-developed standards and guidelines are needed to define office and outpatient practice patterns relating to specific diseases, such as those that have been developed for a number of operations provided in inpatient settings. Criteria also are needed to make reasonable judgments about the frequency, volume, and effectiveness of both procedural and non-procedural physician activities. Ultimately, if guidelines are to influence the volume issue, it will be necessary to directly link payment policies with professionally developed criteria concerning the appropriateness and the effectiveness of various medical and surgical treatments. Our plan is premised on the establishment of such a linkage for surgical services provided to Medicare patients.

Those of us in surgery believe that it is impossible to effectively and efficiently address the volume issue across the entire spectrum of medical services. In most major hospitals, the responsibility for quality assurance and volume issues is assigned to specific departments with the experience and competence to deal with these issues in the context of specific service categories. It is for this reason that we propose an attempt to address the issue of increased volume of services exclusively within the scope of the specific specialty. At the present time,

the volume of services paid for by Medicare is increasing at a rate that exceeds the increase in the aged population. In our view, Medicare will have greater success in dealing with this issue if the program follows the present examples within the medical profession for evaluating the appropriateness and quality of services.

We believe that major steps can be taken now to moderate the growth in Medicare spending, if the government will join with the surgical profession to make such a plan work. Working with the government, we are prepared to develop criteria to determine the appropriateness of various surgical treatments and to assist, as appropriate, in applying such criteria to determine payments for those services under Medicare. Furthermore, we are prepared to help identify unnecessary, outdated, or inappropriate services on a specialty-by-specialty basis.

In addition, we suggest another tool for moderating the expenditures for surgical services. Under this approach, the Secretary of Health and Human Services would calculate actual program expenditures for surgical services in a base year--perhaps 1989. From these amounts, the Secretary would be directed to determine on a budget-neutral basis a surgery-specific conversion factor that would be applicable to Medicare surgical services, using a new, blended fee schedule for Medicare surgical procedures to be described later in this statement. Under the plan, this 1989 conversion factor would be updated for 1990 so as to remain budget neutral with respect to any expenditure goals for Medicare set forth by the Congress for that year. For 1991 and each year thereafter, the conversion factor would be

increased to reflect changes in the costs of surgical practice, including professional liability costs, and changes in the general earnings levels of other comparable professionals.

The Secretary would be required to determine a national expenditure target for surgical services subject to the blended surgical fee schedule. In estimating this expenditure target for 1991, the Secretary, in consultation with representatives from beneficiary organizations and professional organizations of surgeons, would be required to take into account:

-- population changes, including the total number of beneficiaries covered by Medicare, the age distribution of the enrolled population, and factors affecting morbidity;

-- cost changes, including costs relating to the increased use of new technologies, and cost changes reflected in a market-basket index of practice costs (e.g., expenses for professional liability insurance) relating to surgical services; and

-- estimated changes in the expected demand for and volume of surgical services that are required by Medicare patients.

Starting in 1994, if the Secretary finds that the estimated expenditure target for surgical services covered under the plan--taking into account the factors just described--would yield a significantly lower conversion factor than would result from the process used to update the blended fee schedule, he would be required to submit to Congress recommendations for adjusting future updates in scheduled payment amounts applicable in later

years. In the event that the Secretary makes such a finding, he would be required to consider the views of the PPRC, the surgical community, and beneficiary organizations in developing his recommendations.

We believe that a thirty-six month interval between the effective date of the first phase of the plan--i.e., use of the blended surgical fee schedule--and the setting of the first target expenditure goal is needed in order to develop the infrastructure and data base within the surgical community that would be required for an effective program of volume assessment and compliance with professional standards. We are prepared to make a commitment to develop the needed infrastructure within the surgical community to make this plan work.

Mr. Chairman, we were pleased to learn that the PPRC also supports the concept of expenditure targets. However, there are some differences between the approach advocated by the PPRC and that recommended by the College; for example, the period needed to phase in such a plan. According to the Commission, the national expenditure target is expected to evolve into separate targets that could apply either to separate categories of physicians' services or perhaps on a geographic basis. The College believes that separate expenditure targets should be established on a specialty-specific basis, including at a minimum a separate target for surgical services.

PATIENT PROTECTION PROVISIONS

The principal purposes of the Medicare program are: (1) to provide our older citizens with access to high quality medical care, which we believe has been accomplished; and (2) to provide

beneficiaries with reasonable economic protection against the costs of these services. We believe that major changes in payment policies under the program for hospital and physicians' services must be considered with these goals in mind. We note that the PPRC also is concerned about beneficiaries' financial burdens under any new payment approach for physicians' services under Medicare. Mr. Chairman, you will note some similarities between the Commission's recommendations in this area and those of the College.

As you know, a significant number of our members and other physicians are participating physicians under Medicare and currently accept assignment in all Medicare cases. According to recent data from the Health Care Financing Administration, for example, 52.2 percent of general surgeons are Medicare participating physicians. In addition, a large number of physicians, who have some objections to signing participation agreements, nevertheless frequently accept assignment for older patients, and particularly for those with more limited means. Thus, it seems appropriate to reexamine Medicare's current assignment experience and consider ways to improve the financial protection for surgical services afforded by Medicare under a new payment approach. Physicians wishing to sign participation agreements or to accept assignment in any other cases would be allowed to continue to do so under our plan.

Under the plan we propose, surgeons--working with beneficiary organizations and with the Congress--are prepared to support changes in the current assignment procedures under Medicare. One of these changes would involve the establishment

by Congress of a national income level below which the new Medicare schedule of fees for surgical services would be considered as payment in full. For those beneficiaries with incomes below this threshold, many of whom are likely to reside in rural areas, Medicare would pay physicians 80 percent of the scheduled payment directly and the patient would remain liable for only the 20 percent coinsurance. No additional charges to these qualifying patients could be made. Physicians would be permitted to charge their regular fees for all other patients, subject to Medicare's existing rules.

There are obviously some administrative considerations that would need further study to avoid claims problems for physicians and to protect the privacy of patients. But we believe that these difficulties can be overcome in a workable manner and are prepared to discuss a number of options with Congress about how to implement such a plan.

The College further believes that Congress also should consider the assignment rules affecting patients who have no opportunity to exercise their choice of surgeon, as in the case of a patient who has an acute illness and who requires emergency surgical services. Where no choice of a surgeon is available, the patient has no real opportunity to obtain the most favorable fee options, so that some patient protection against higher charges might seem warranted in such cases. We are now studying this proposition in more detail, but are not as yet prepared to recommend a specific way to address this issue. In addition, we, of course, recognize that some Medicare beneficiaries living in rural areas may have a limited number of surgeons from whom to

choose, and that special consideration will need to be given to these unique circumstances in developing appropriate changes in Medicare assignment policy.

Lastly, we are concerned about the effects of any new valuation process that results in Medicare paying an above-market current price level for services and, thereby, potentially increasing the costs of those services for patients and, perhaps, the government, too. For example, if increases were to be made in Medicare's allowed amounts for some services, but not made in the maximum allowable actual charges that also apply to those services, the effects on patients will be mixed. The coinsurance costs for all patients for these services will rise, though any extra billing costs for non-assigned claims would be reduced. The premium costs for all enrollees also will increase as well. Thus, we believe that Congress should take steps to ensure, in some clear fashion, that Medicare patients benefit from steps that increase Medicare payments for certain services so that beneficiaries will not be unduly burdened by also paying a substantially larger copayment.

BLENDED FEE SCHEDULE FOR SURGICAL SERVICES

Mr. Chairman, an integral element of the College's proposal provides for the establishment of a blended fee schedule for surgical services under Medicare that would strike a balance between both supply-side and demand-side factors in determining relative values for the services covered under the proposed plan.

We wish to make clear that we support the use of a relative value scale in any Medicare fee schedule system. However, the College has major concerns about the use of a resource-based ap-

proach as the sole basis for establishing the value of services in such fee schedules. In general, we have felt that, among other things, this approach simply does not take into account the greater diagnostic or therapeutic value of specific services for patients, it ignores the quality of the services provided, and it fails to consider other factors that play a major role in determining the value of most other goods and services that are purchased in our society.

Moreover, no relative value scale, including the Harvard approach, offers any real solution for moderating the costs of medical and surgical services under the program. In fact, one of the effects of the Harvard RBRVS could be to raise Medicare fees paid to some physicians well above the levels they now charge or are paid by other private insurers for providing the same services. As we have noted, we believe that this would significantly increase the costs of those services not only for the government, but also for patients through higher premium and coinsurance costs. It also seems to us that substantial increases in payments for any services not only would increase the unit cost of those services, but also would provide strong financial incentives to increase the volume of these services. Without a plan for dealing with these volume effects under a resource-based approach, we believe Medicare costs would rise even more rapidly than they have in the past.

On the other hand, the major relative value reductions proposed under the RBRVS approach, including the effects on many procedural services, could seriously affect access to some physicians' services, particularly in rural areas, and reduce the

interest of many physicians in signing Medicare participation agreements or accepting assignment. In turn, problems of access to certain types of physicians' services obviously could have an impact on rural hospitals and could alter their ability to provide the complement of services now available in these facilities.

Academic medical centers also could be affected in terms of the size and composition of graduate medical education programs. This, in turn, could influence the types of patients that are seen within a particular institution, as well as the types of services that are offered by the institution to the community.

We want to make it very clear, however, that we do not oppose using supply-side considerations, or resource input costs, as one factor in determining the value of services provided by physicians. Obviously, all physicians must carefully take into account such matters as their costs of practice when they establish their fees. Surgeons, for example, are especially aware of the effects of professional liability costs on the fees they must charge patients for their professional services. But, we believe that relying exclusively on physicians' judgments about the input costs of services in order to set relative values is conceptually incomplete. We also believe that there are special problems in surgery, such as professional liability costs, that need to be considered carefully in constructing any cost of practice adjustments in fees for surgical services. To that end, we strongly support the PPRC's recommendation that professional liability insurance premiums should be treated as a separate practice cost factor under any new Medicare fee schedule.

Therefore, we propose the development of a fee schedule for surgical services that would take into account not only the supply-side considerations reflected in a resource-based approach to payment, but also important demand-side considerations and the interests of patients that should not be ignored in the process of setting values.

To start, we believe that the Congress should consider legislation authorizing the Secretary to establish an explicit list of surgical services now provided to Medicare patients that would form the basis of a new approach to payment for those services. Non-operative invasive procedures that may be provided by both medical and surgical specialists would not be affected by the plan. Thus, only the services that are typically provided by physicians with the necessary surgical training or experience to perform such services would be part of the plan we have in mind. On the basis of our preliminary study of Medicare data and the scope of this plan, we estimate that surgical services covered by the proposal account for about 30 percent of all expenditures for physician services under Medicare.

Under our proposal, we anticipate that further efforts will be made by the PPRC and the Secretary to improve upon the methodology used in the Harvard RBRVS project to yield a more valid set of estimates of the resource costs involved in producing physicians' services. We also anticipate that recommendations will be made concerning those aspects of the Harvard RBRVS project that need further refinement, as well as the aspects that can be implemented more quickly. This is of concern to us, since not all of the surgical specialties were included in the initial

phase of the Harvard project. Moreover, some of the results from the first phase need to be reexamined before the RBRVS results could be used.

We also believe that the Congress should direct the Secretary to conduct research into those factors that should be used to establish demand-side considerations affecting relative values for surgical services, including such possibilities as looking at market prices for services, the efficacy of alternative treatments as measured by data on such matters as mortality reduction and adverse consequences of treatment, and the importance of treatments to patients. Even the Harvard researchers seem to think there is merit in looking at physician charge data as a basis for making relative value calculations within different families of physicians' services.

We do not think that policymakers will have to wait very long for the results of the Secretary's work in this area in order to identify and develop the kinds of information needed about demand-side considerations to determine relative values for the services that would make up a new Medicare fee schedule for surgery. The results of the Secretary's investigations in this area would be used to develop a new, blended schedule for surgical services provided to Medicare patients that would be applied as early as January 1991. Should the Secretary's work on demand-side factors not be ready by that time, we believe that physician charges could be used in the interim as a "rough" approximation of demand considerations.

In our view, the relative values of all physicians' services should be based on a composite of supply-side and demand-side

values using equal weighting of both factors. However, we obviously cannot speak for other physicians on this point and, therefore, have limited our recommendations for a "blended" approach only to those services performed by surgeons.

PHASED IMPLEMENTATION

Mr. Chairman, we believe that rapid implementation of major payment reform changes could adversely affect patients by increasing some of their costs or perhaps by limiting their access to services. Thus, we have urged this Committee and other policymakers to proceed carefully and in stages to bring about significant changes in payment policy. These considerations suggest that major reform actions should be put in place over a reasonable transition period. We have developed a preliminary implementation schedule for our proposals consistent with these goals.

The major changes for which phased implementation seems appropriate are, first, to substitute the blended fee schedule for surgical services for the current reasonable, customary and prevailing fee-based methodology and, second, to implement the expenditure target program, including the development and application of criteria for judging the appropriateness and effectiveness of surgical services.

As noted above, the blended fee schedule for surgical services would be developed for use beginning in 1991. Under the plan, movement toward the full 50/50 blend of supply-side and demand-side considerations would commence in that year and be completed by 1996. In the interim, relative values based on current charges would be phased in with the new, blended values cal-

culated by the Secretary for Medicare surgical services. The weight assigned to the new, blended values would increase steadily during the transition period, while the weight assigned to current charges would decrease gradually, as follows:

Year	Current Charge Weight	Blended Schedule Weight
1990	6/6	0
1991	5/6	1/6
1992	4/6	2/6
1993	3/6	3/6
1994	2/6	4/6
1995	1/6	5/6
1996	0	6/6

We believe that a less lengthy schedule is needed for phasing in geographic differentials under a blended fee schedule, with three years perhaps being a realistic goal after the data became available to make such adjustments. Special care is needed in the development of a new geographic differential policy so that pertinent factors, including the costs of practice in rural areas, are appropriately taken into account. Both the differential used under Medicare's current methodology as well as a differential used under a reformed approach would be used. A composite rate of the two differentials would be calculated and phased in as follows:

Year	Current Differential Weight	Reform Differential Weight
1990	3/3	0
1991	2/3	1/3
1992	1/3	2/3
1993	0	3/3

We have not proposed a specific transition schedule at this time relating to the volume of services issue. We recognize, however, that the expenditure target provisions contained in our

plan place the responsibility squarely on the surgical community to develop effective criteria for determining the appropriateness of care and for obtaining compliance with those criteria. Thus, we propose that the Secretary, after receiving further advice from the PPRC, from organizations representing surgery, and from groups representing beneficiaries, develop a reasonable schedule for implementing proposals relating to volume.

SUMMARY

In conclusion, Mr. Chairman, we are recommending a comprehensive plan for addressing the pricing and volume of surgical services under Medicare, and for providing important, new beneficiary financial protections. The key features of our plan are:

1. A fee schedule for surgical services under Medicare based on a 50/50 blend of resource costs and demand-side factors, effective in 1991;
2. An increased emphasis on the development, dissemination, and application of practice guidelines, coupled with a determination of a national expenditure target for surgical services, effective in 1994;
3. Payment for services provided to Medicare patients with incomes at or below a level determined by Congress on the basis of the scheduled payment amounts only; and
4. Phased implementation of the new payment system, beginning in 1991.

We fully intend to develop our proposals in greater detail. American surgery is committed to a constructive role in advising and participating with the Congress, the PPRC, and the Secretary in developing the initiatives that are necessary to moderate costs and to maintain the quality of, and access to, surgical services in both urban and rural areas.

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Mr. WAXMAN. Thank you very much, Dr. Ebert.
Dr. Rogers.

STATEMENT OF LEE ROGERS

Mr. ROGERS. Thank you, Mr. Chairman. My name is Lee Rogers. I'm a practicing radiologist and chairman of the radiology department at Northwestern University Medical School in Chicago. I serve as chairman of the Board of Chancellors of the American College of Radiology.

With me today is Dr. James Moorefield, a radiologist from Sacramento, CA, vice chairman of the ACR Board, and chairman of the committee which worked with the Health Care Financing Administration to develop the radiology relative value scale, resulting in a 3 percent reduction in expenditures for Medicare radiologic services.

Based on our experience, we would like to address three major points: No. 1, relative value scales for physician reimbursement are readily developed within each specialty; No. 2, implementation of a relative value scale for all physicians is rife with administrative problems for all concerned—HCFA, the carriers and physicians; and, No. 3, wide geographic variations in reimbursement identified by the radiology RVS are of great concern.

These differences will not be corrected by a relative value scale but by the establishment of appropriate dollar conversion factors.

The American College of Radiology appreciates the opportunity to present our experience in the development and implementation of a relative value scale for the practice of radiology. We thank you, Mr. Chairman, for your assistance and guidance of the legislative language into the law which mandated the radiology RVS. We believe we have created a positive approach to solving some of the inequities of the present Medicare reimbursement system. We are proud of the cooperative relationship we built with Congress and HCFA in working to carry out the intent of the law.

As to the specialty specific relative value scale, physicians within a specialty are acknowledged experts on the specialty's procedures and their complexity and value to the patient. The ACR believes that because those physicians are the most knowledgeable, they are, therefore, the best qualified to develop a relative value scale for their specialty.

Each individual specialty has read access to the information required to develop an RVS. It is thus possible to have accurate and acceptable results in a relatively short time, as evidenced by our experience with the radiology RVS. It was only 2 years from the first ACR testimony which stated that the College would like to work with the Congress on a positive approach to the Medicare reimbursement process to the April 1, 1989 implementation date of the radiology RVS.

Recognizing the complexities and time demands required to produce and RVS, the ACR would suggest a minimum of 2 to 2½ years for a medical specialty to develop a relative value scale.

The American College of Radiology's process of gathering and using information for the development of our relative value scale

was comprehensive, a time and labor intensive process of surveying the majority of radiology practices in the United States.

We used the experience or charge-based method in developing our relative value scale, believing that the charge data could be easily obtained from our members and that such charges best represent the current practice of radiology. There was also a survey designed to measure critical factors determining the value of a service or procedure which served as a benchmark against which the charge data was compared. In this way, potentially inappropriate values, secondary to distortions produced by existing payment patterns, were identified and corrected.

A steering committee and seven subspecialty panels, including nuclear medicine, analyzed the data from the survey. The committee and subspecialty panels discussed all the survey results and ultimately reached a consensus on the relative values of each procedure.

As to the implementation, the greatest problems encountered with the radiology RVS have been during the implementation phase. With the problems being so significant for the implementation of a fee schedule for one specialty representing less than 5 percent of all physicians, we believe that any relative value scale implementation, no matter what the source, that encompasses many or all disciplines of medicine would be an exceedingly difficult undertaking.

The two important components of any fee schedule are the relative value unit and the conversion factor. The conversion factor—a dollar value—is multiplied by the relative value unit to derive the fee schedule for each procedure. The ACR, through its survey and consensus process, established the RVS which the Health Care Financing Administration accepted for use with the radiology fee schedule. The Medicare carriers, the insurance companies contracted by HCFA to administer part B Medicare funds, are responsible for calculating the conversion factors.

The radiology relative value scale was implemented on April 1, 1989, 3 months later than mandated in the law. The ACR requested and was granted a delay because of the significant problems we discovered in the calculation of the conversion factors.

Initial conversion factors for the January 1 implementation date resulted in reductions for radiology practices much greater than the mandated 3 percent. This prompted the ACR to ask for the delay and HCFA to ask the ACR to go to different carriers to examine their data.

We appreciate the cooperation of HCFA and some of the individual carriers in this auditing process. Some carriers have been much more cooperative and diligent than others.

If I could, Mr. Chairman, there is one last——

Mr. WAXMAN. The rest of your statement will be printed in the record.

Mr. ROGERS. All right. Then I will reluctantly conclude at this point.

[The prepared statement of Mr. Rogers follows:]

Testimony of the

American College of Radiology

Before the

House Energy & Commerce Subcommittee on Health

May 25, 1989

Thank you Mr. Chairman. My name is Lee Rogers. I am a practicing radiologist and chairman of the radiology department at Northwestern University Medical School in Chicago, Illinois. I serve as Chairman of the Board of Chancellors of the American College of Radiology. With me today is Dr. James Moorefield, a radiologist from Sacramento, California, Vice-Chairman of the ACR Board and chairman of the committee which worked with the Health Care Financing Administration to develop the radiology relative value scale.

Based on our experience we would like to address three major points.

1. Relative value scales for physician reimbursement are readily developed within each specialty.

2. Implementation of a relative value scale for all physicians is rife with administrative problems for all concerned, HCFA, the carriers and physicians.

3. Wide geographic variations in reimbursement identified by the radiology RVS are of great concern.

The American College of Radiology appreciates the opportunity to present our experience in the development and implementation of a relative value scale for the practice of radiology. We thank you, Mr. Chairman, for your assistance and guidance of the legislative language into the law which mandated the radiology relative value scale. We believe we have created a positive approach to solving some of the inequities of the present Medicare reimbursement system. We are proud of the cooperative relationship we have built with Congress and the Health Care Financing Administration in working to carry out the intent of the law.

SPECIALTY SPECIFIC RELATIVE VALUE SCALE

Physicians within a specialty are acknowledged experts on the specialty's procedures and their complexity and value to the patient. The ACR believes that because those physicians are the most knowledgeable they are therefore the best qualified to develop a relative value scale for their specialty.

Each individual specialty has ready access to the information required to develop an RVS. It is thus possible to have accurate and acceptable results in a relatively short time as evidenced by the radiology RVS. It was only two years from the first ACR testimony which stated that the College would like to work with the Congress on a positive approach to the Medicare reimbursement process to the April 1, 1989 implementation date of the radiology RVS.

Recognizing the great complexities and time demands required to produce an RVS, the ACR would suggest a minimum of 2 to 2 1/2 years for a medical specialty to develop a relative value scale.

The American College of Radiology's process of gathering and using information for the development of our relative value scale was comprehensive, a time and labor intensive process of surveying the majority of radiology practices in the United States.

We used the experience or charge-based method in developing our relative value scale believing that the charge data could be easily obtained from our members and that such charges best represent the current practice of radiology. There was also a survey designed to measure critical factors determining the value of a service or procedure which served as a benchmark against which the charge data was compared. In this way, potentially inappropriate values secondary to distortions produced by existing payment patterns were identified and corrected.

A steering committee and seven subspecialty panels analyzed the data from the survey. There were panels on: 1) general radiology; 2) angiography, interventional and neuroradiology; 3) ultrasound; 4) radiation oncology; 5) CT/MRI; 6) nuclear medicine; and 7) technical cost. The committee and subspecialty panels discussed all the survey results and ultimately reached a consensus on the relative values of each procedure.

IMPLEMENTATION

The greatest problems encountered with the radiology RVS have been during the implementation phase. With the problems being so significant for the implementation of a fee schedule for one specialty, we believe that any relative value scale implementation, no matter what the source, that encompasses many or all disciplines of medicine would be an exceedingly difficult undertaking.

The two important components of any fee schedule are the relative value unit and the conversion factor. The conversion factor (a dollar amount) is multiplied by the relative value unit to derive the fee schedule amount for each procedure. The American College of Radiology through its survey and consensus process established the relative value units which the Health Care Financing Administration accepted for use with the radiology fee schedules. The Medicare carriers, the insurance companies contracted by HCFA to administer Part B Medicare funds, are responsible for calculating the conversion factors.

The radiology relative value scale was implemented April 1, 1989, three months later than mandated in the law. The ACR requested and was granted a delay because of the significant problems we discovered in the calculation of the conversion factors.

Initial conversion factors for the January 1 implementation date resulted in reductions for radiology practices much greater than the mandated 3%. This prompted the ACR to ask for the delay and HCFA to ask the ACR to go to different carriers to examine their data.

We appreciate the cooperation of HCFA and some of the individual carriers in this auditing process. Some carriers have been much more cooperative and diligent than others.

For the radiology RVS there are 240 conversion factors, one for each Medicare locality. Medicare localities have existed since the Medicare program began and were established based on political or economic subdivisions within a state.

The task before the 54 carriers in establishing these conversion factors was tremendous and we recognize that. However, we have found in our examination that the consistency and completeness of data from carrier to carrier varies widely. Such inconsistencies have hampered the implementation of the radiology RVS and would severely hamper the implementation of a larger RVS for all of medicine.

Carriers have found it exceedingly difficult, for whatever reason, to identify with accuracy expenditures for radiologist reimbursement during the base period of 1987-1988. Their data base is not as accurate or complete as one might presume and the difficulties encountered in the extraction of the necessary information from the data base far exceeded what was expected.

The implications of this experience for the broader implementation of relative value scales for other or all physician's services are of obvious importance. The implementation of any fee schedule

based on past expenditures will most assuredly encounter similar problems. The broader the scope of medicine included and the more rapid the rate of introduction, the greater the magnitude of the difficulties to be encountered.

An additional difficulty encountered is the lack of uniform procedure coding. In order to develop a national RVS, a specialty needs to have greater input into producing a uniform coding structure across the country.

Because the radiology RVS is a national relative value scale the ACR used the national HCPCS coding nomenclature in developing the RVS. However, there are many local codes used across the country but not included in the national coding system. It is impossible to be comprehensive in developing an RVS when many areas of the country use different codes not included in the national HCPCS nomenclature. We urge HCFA and Congress to work toward modifying these coding inconsistencies to be more responsive to the goal of accurate reporting and reimbursement.

GEOGRAPHIC VARIATIONS

There exists tremendous geographic differences among the radiology RVS conversion factors due to the historic inaccuracies of the usual, customary and reasonable (UCR) payment system.

When initially proposing locality-wide conversion factors (which we felt would be least disruptive to existing payment patterns), we did not anticipate the wide range of conversion factors we have seen, a ratio of 2.5 to 1 from highest to lowest across the country.

The range of conversion factors has produced the seemingly inexplicable, indefensible situation where a radiologist in one part of the country is being reimbursed half of what another radiologist is being reimbursed for the same service. There are sizeable differences, as much as 15 to 20% in conversion factors in locations which are just across county lines or just across a river in another state. Such wide variations in reimbursement are of great concern. Are there similiar wide variations in payment for other physicians services? We do not know.

We urge development of a broader-based conversion factor with an index to reflect the legitimate differences in practice cost and cost of living across geographic areas. We believe a broader-based conversion factor would create a more equitable system.

For the hearing record, we will also submit our RVS report to HCFA, our February 8 testimony to the Physician Payment Review Commission and our testimony of April 17 to the Ways & Means Subcommittee on Health.

Mr. WAXMAN. Thank you.

If you wouldn't mind, please pass the microphone over to Dr. Bishop, who is next.

STATEMENT OF MICHAEL D. BISHOP

Mr. BISHOP. Thank you, Mr. Chairman, and members of the subcommittee.

I am Mike Bishop, an emergency physician in Bloomington, IN. I appear today on behalf of the more than 12,000 members of the American College of Emergency Physicians. We appreciate this opportunity.

Emergency medicine was not included in the first phase of the Harvard Resource-Based Relative Value Scale study. However, emergency medicine is being examined in the second phase. The Harvard project represents a major contribution to the development of an RVS for physicians' services that more accurately reflects the actual inputs needed to produce these services.

The PPRC has proposed some important modifications to the Harvard methodology that we feel may make it feasible to use a resource-based RVS approach. In recent years, legislative changes have been enacted to redress some of the current payment imbalances for primary care services, including emergency department visit services. The issue of special recognition for primary care services arises because more time will be needed before a new payment system based on resource cost can be implemented. We hope this subcommittee will continue to recommend differential treatment for primary care services, including emergency department visits, in connection with any payment actions taken by Congress on an interim basis.

We have some concerns, Mr. Chairman, about the PPRC's recommendation to move rapidly and implement a Medicare fee schedule in 1990. There is still much more to be learned before major revisions and payment rules are adopted. The impact on both beneficiaries and physicians of some of the proposed changes is not very clear at this time but could be significant. Our own participation in the Harvard study, for example, is only just beginning. More time may be needed to develop the data needed before a workable fee schedule can be adopted. We urge the Congress keep these considerations in mind when deciding the appropriate time to initiative further physician payment reforms.

ACEP agrees with the PPRC that there are serious problems with the use of the current codes in defining physician work, particularly some of the codes for emergency department visits. The Commission is recommending that the coding system be revised so that time would be used as a significant factor in establishing different levels of service. There is a unique difficulty with linking the valuation of emergency services to time. Many emergency services need to be provided quickly. In fact, their value lies in their quick application.

ACEP believes that the value of emergency services should be more closely linked to such factors as knowledge, skill, effort and stress, and not disproportionately to time.

Mr. Chairman, one of the major recommendations from the PPRC calls for a national target expenditure plan. ACEP opposes this recommendation in its current form, primarily because it fails to recognize the nature of the demand for emergency services by the Medicare population. Emergency physicians do not determine, nor control, the number of patients who present to emergency departments. Moreover, ACEP strongly opposes any steps that would discourage patients from seeking medical care when they are acutely ill or believe they need urgent medical attention. However, if Congress decides to adopt an expenditure target plan, emergency services should be specifically excluded from that plan.

Finally, Mr. Chairman, I would like to share our views about the need for improvements in Medicare's assignment procedures. Based on our detailed study of Medicare data on emergency department visit codes, emergency physicians appear to have the highest assignment rates of all physicians, accepting assignment on approximately 90 percent of all claims.

We understand the Commission has, in principle, endorsed the need for making changes in Medicare's assignment policy where beneficiaries have no meaningful choice of provider. Since patients who present with emergencies have no meaningful choice of provider, and since emergency physicians who treat them have no choice in the selection of which patients they treat, we agree that Medicare's current assignment rule should be changed under a new Medicare fee schedule. If, as part of this reform process, payments for emergency physician services are reasonably valued and paid appropriately, the American College of Emergency Physicians is prepared to support the acceptance of such payment levels as payment in full, thereby relieving Medicare patients of balance billing obligations.

Thank you very much.

[The prepared statement of Mr. Bishop follows:]

TESTIMONY

of the

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Mr. Chairman and Members of the Subcommittee, I am Michael Bishop, M.D., F.A.C.E.P., a practicing emergency physician in Bloomington, Indiana, and Chairman of the Physician Payment Committee of the American College of Emergency Physicians (ACEP). I appear today on behalf of the more than 12,000 members of ACEP. The College appreciates this opportunity to comment on various aspects of current Medicare physician payment policy.

Relative Values and a Medicare Fee Schedule

Mr. Chairman, emergency medicine was not among the 18 specialties included in the first phase of the Harvard Resource-Based Relative Value Scale (RBRVS) study completed last fall. However, emergency medicine is among the specialties that are now being examined in the second phase of the project. Overall, ACEP believes that the Harvard RBRVS project represents a major contribution to the development of a relative value scale for physicians' services that more accurately reflects the actual inputs needed to produce such services.

We further believe that the Physician Payment Review Commission has proposed some important modifications to the Harvard methodology that make it feasible to use a resource-based relative value approach to Medicare payments for physicians' services.

On the basis of these modifications, the PPRC has recommended that Medicare's current usual, customary and prevailing payment system for physicians' services be replaced with a fee schedule that is based primarily on resource costs. ACEP supports this recommendation. The work at Harvard and the research by the Commission clearly show that physician evaluation and management services are systematically undervalued when compared with most other physicians' services provided to patients. Most of our activities consist of these kinds of services. This finding is of particular interest to emergency physicians who have the responsibility to react quickly and decisively in assessing and dealing with the serious nature of medical problems treated in the emergency department. In effect, patient evaluation and management at these critical moments are what encompasses the practice of emergency medicine.

While resource costs have received most of the attention in discussions about ways to establish a more rational and equitable Medicare payment system, the importance of some services relative to other services has been recognized by Congress in an additional way. Based on recommendations from the Commission, changes have been enacted to redress some of the current payment imbalances for primary care services, including emergency department visit services. The issue of special recognition for primary care services at present arises because more time will be needed before a new Medicare payment system based on resource costs can be implemented. We hope this Subcommittee will continue to recommend differential treatment for primary care services, including emergency department visits, in connection with any payment actions taken by Congress on an interim basis.

Fee Schedule Implementation

We have some concerns, Mr. Chairman, about the PPRC's recommendations to move rapidly with implementation of a Medicare fee schedule in 1990 leading to full implementation by 1992. It seems to us that there is still much more to be learned before major revisions in payment rules are adopted by law.

We recognize, of course, that the Congress is anxious to approve a better approach to physician payment than now exists. However, the impact on both beneficiaries and physicians of some of the proposed changes recommended by the Commission is not very clear at this time, but could be significant. Our own specialty participation in the Harvard study, for example, is only just beginning, and more time may be needed to develop the data and analysis needed for all specialties before a workable fee schedule can be adopted. It is also essential that changes of the magnitude proposed be based on information -- in addition to relative value calculations -- that is both accurate and current, especially in the case of physician cost of practice data. We urge that Congress be mindful of these considerations in judging the appropriate timing of physician payment reform initiatives.

Defining Physicians' Services

Mr. Chairman, the Commission has concluded that reforms in the coding and definition of physicians' services are needed in order to implement a fee schedule based on resource costs. One of these reforms involves improvements in the current codes used

for evaluation and management services -- commonly referred to as the visit codes. Results from the Harvard study suggest that there are problems with the current codes used by physicians to accurately reflect their work effort because the levels of service are not precisely defined. Interpretations of the visit codes varies widely, not only by specialty and geographic location, but also among individual physicians.

ACEP agrees with the PPRC that there are serious problems with the use of the current codes in defining physician work, and that there are particular problems with some of the codes for emergency department visits. We also agree with the Commission that the ambiguity inherent in the current codes could create serious problems with valuing and paying for services in a fee schedule.

As we understand it, however, the Commission is now recommending that the coding system be revised so that time would be used as a significant factor in establishing different levels of service --and, presumably, therefore, different relative values for these services, as well. Such a recommendation may be appropriate for some physician specialties, but we believe there is a unique difficulty with linking the valuation of emergency services to time. Many emergency services and procedures need to be provided quickly, and their value lies in their quick application. Often, the longer it takes to provide a service in an emergency, the lower the value to the patient.

ACEP believes that the value of emergency department visit services should be more closely linked to such factors as knowledge, skill, effort and stress, and not disproportionately to time. We have communicated our views about the special problem

of using the time factor in emergency settings to the staff of the Commission and to Harvard researchers looking at the services provided by specialists in emergency medicine. The College has also recently completed its own review of coding issues involving emergency department services, and intends to share its recommendations with the PPRC and with officials of the Health Care Financing Administration as soon as possible.

Target Expenditures

Mr. Chairman, one of the major recommendations from the PPRC calls for approval of a national target expenditure plan for physicians' services under Medicare. More specifically, the Commission recommends beginning with a single target at the national level, but anticipates that the policy could evolve into one with multiple geographic or specialty-specific expenditure targets.

ACEP opposes this recommendation in its current form for a number of reasons, but primarily because it fails to recognize the nature of the demand for emergency services by the Medicare population. Among other things, the theory behind a target expenditure plan is to establish incentives to limit expenditures for physicians' services that take into account both the volume and the price of the services provided. Emergency physicians, however, do not determine, nor can they control, the number of patients who present to emergency departments of hospitals. Moreover, from a public policy standpoint, ACEP strongly opposes any steps that would tend to discourage any patients from seeking needed emergency care when they are acutely ill or believe they need urgent medical

attention.

Thus, the idea of establishing an expenditure target for emergency services --as part of an overall scheme or under a multiple target plan -- could be problematic. For one thing, we do not see how such expenditures could be reasonably predicted in advance. If, however, Congress decides to adopt an expenditure target plan, Congress should direct that emergency services be excluded from the plan.

Medicare Assignment

Finally, Mr. Chairman, I would like to share the College's views about the need for improvements in Medicare's assignment procedures. We believe that major payment reform changes should not be undertaken without careful consideration of the financial implications of those changes on patients.

ACEP is pleased to note, following a detailed examination of Medicare Part B claims data, that emergency physicians appear to have the highest assignment rates of all physicians who provide services to patients under the Medicare program. For example, our study of Medicare data on emergency department visit codes shows that assignment is taken on about 90 percent of all claims. There may be several reasons why the assignment rate is not even higher than this, the most important of which has to do with the unreasonably low amounts paid by some Medicare carriers for patient management and evaluation services in general, and for emergency physicians' services in particular.

We understand that the Commission has, in principle, endorsed the need for making changes in Medicare's assignment policy where beneficiaries have no meaningful choice of provider, including in emergency circumstances. We would also point out, however, that unlike other practitioners, emergency physicians have no choice in the selection of which patients they will treat. In fact, it has long been the position of the College that no patient coming to the emergency department should be denied emergency medical care. I would further add that Federal law also requires that all patients be examined and treated as if they have potentially life-threatening or other serious illnesses or injuries. In other words, we believe we have an ethical, moral, and legal responsibility to evaluate, and where needed, to treat all patients presenting to the emergency department.

Since patients who present with emergencies have no meaningful choice of provider, and, since the emergency physicians who treat them really have no choice in the selection of which patients they will treat, we agree that Medicare's current assignment rules should be changed under a new Medicare fee schedule. And if, as part of this reform process, payments for emergency physician services are reasonably valued and paid appropriately, the American College of Emergency Physicians is prepared to support the acceptance of such payment levels as payment in full -- thereby relieving Medicare patients of balance billing obligations. We intend to meet with the Commission to explore this matter further.

Thank you, Mr. Chairman, for this opportunity to testify. I would be pleased to answer any questions you or your colleagues may have.

Mr. WAXMAN. Thank you, Dr. Bishop.
Lastly, I want to call on Dr. Holtgrewe.

STATEMENT OF H. LOGAN HOLTGREWE

Mr. HOLTGREWE. Thank you. I am Logan Holtgrewe, a urologist from Annapolis, MD, and an officer of the American Urological Association.

Our Association feels that the adoption of a resource-based relative value scale as a basis for a national fee schedule at this time is premature. The science and methodology of development of relative value scales are in their infancy and are currently incomplete.

Eight of 18 specialties studied have requested that Dr. Hsiao reevaluate their specialty, raising questions as to the accuracy of the current value scale that he produced. But our most serious concern is the lack of uniformity of what is actually being valued.

Most all urologists use a global fee concept. Their fee for a surgical procedure includes much of the pre- and postoperative care. The Physicians Payment Review Commission is currently completing an indepth study of global fees. During the study I represented urology and worked with the PPRC, and I was extremely impressed with the careful and scientific manner in which this project was conducted. I really admired the leadership of Dr. Roz Lasker, who chaired this study. It was quite well done.

Last week our Association completed an assessment of each and every operation in our field, along with those pre- and postoperative services surrounding it, that will not be fitted into the global picture by the PPRC. This data will be in their hands by months end.

The AUA is also working with the PPRC, along with the specialties of internal medicine and rheumatology, in an evaluation of office and hospital cognitive services. This study is also incomplete. These these data and materials are available and can be worked into the relative value scale, there is simply no way, in our estimation, that an accurate assignment of value of services can be made at this time, this year.

Further, we feel that the evaluation of an expenditure target, or the imposition of an expenditure target, is inappropriate. We feel it represents a form of rationing of health care and it does absolutely nothing to address the important issue—indeed, the most important issue—quality of care.

Our Association feels that the only logical way to control health care costs and the volume of services, which in the long run really is the biggest problem, is to establish precise patient care guidelines. This would ensure quality of care while at the same time controlling volume of services to those which are truly worthwhile. Indeed, the AUA has already developed guidelines for transurethral prostatectomy, and we have provided these to PRO's throughout the United States. The AUA is so convinced that this is the right way to go, and is so committed to this course, that we have budgeted this year $500,000 of our own funds for the development of guidelines within our specialty.

Hand in hand with patient care guidelines is the need for outcome research to assure that those things we physicians are doing

are truly effective. In this regard, the AUA is presently embarked with Dr. John Wennberg of Dartmouth University, a noted outcome research investigator, into a study of transurethral prostatectomy. We meet with him and his colleagues next week in order to begin what we feel and what Dr. Wennberg feels will be an epic research effort.

But the government must help us. The AUA and specialty organizations like ourselves have professional knowledge but we lack all of the adequate funding we need, and our resources are certainly limited. We applaud the government's interest in outcome research and regard it as an excellent investment for the future. Our current TURP study could use some support, and so could our guideline projects. However, we have one other problem. We certainly do not wish to run afoul of the Federal Trade Commission and we have to look to Congress for help and guidance in that area.

So, in conclusion, Mr. Chairman, the AUA feels that current resource-based relative value scales are incomplete. They need to be completed and must be field tested in limited areas before they are installed nationally. We feel that expenditure targets are rationing and are not appropriate. Patient care guidelines and outcome research are the only means of controlling costs and volumes, at the same time assuring quality of care. Until these guidelines and until these outcome research papers can be placed into perspective by a cooperative effort of the PPRC and the very specialty societies, it would seem to us that small, across-the-board cuts for all physicians is the best way to achieve immediate short-term savings until the long-term definitive plan can be placed into position.

I would like to add, in conclusion, that I heard the testimony this morning of Congressman Slattery and I would like to reinforce what he says. I trained at Kansas and I came from that State. The care of the individual in the rural or small community setting today is not just primary care. Rather, it is the availability of specialty care as well.

About a third or more of the income of American urologists comes from one operation—prostate surgery. It has been on the "overvalued" list and has been hit and may well be hit again. The RBRVS that we see from HCFA shows, although perhaps somewhat less of a reduction in the rural area than in the urban one, it is still a reduction. Where is the incentive, then, for the urologist to remain in this rural setting, where I would point out there might be one or two urologists. If he decamps, then what lies ahead for the patient who needs care: a long trip to Denver, Kansas City or Wichita.

I thank you on behalf of our Association.

[Testimony resumes on p. 223.]

[The prepared statement of Mr. Holtgrewe follows:]

STATEMENT OF

AMERICAN UROLOGICAL ASSOCIATION

Mr. Chairman and Members of the Subcommittee:

My name is H. Logan Holtgrewe, M.D. I'm a practicing urologist from Annapolis, Maryland, and Treasurer of the American Urological Association. On behalf of the members of the AUA, I'm pleased to present their views on the recommendations of the Physician Payment Review Commission (PPRC) and related issues.

RECOMMENDATIONS OF THE PHYSICIAN PAYMENT REVIEW COMMISSION

PPRC has spent much time working on this report and AUA has been an active participant in several aspects of it. We applaud the openness of their process and the excellence of their staff. While AUA does not always agree with their conclusions, we recognize that PPRC has tried hard to resolve some difficult issues and has been open to opposing views.

AUA is, however, very concerned that there may be a rush to judgment in favor of PPRC's proposed fee schedule without completing the work that PPRC recommends and without adequate testing of the concepts in the real world. The PPRC report is filled with recommendations for additional studies and work. For example, on page 31 the Commission notes: "However, there are several areas where the methodology must be improved. Once the methodology has been refined, the data from those specialties already studied in Phase I must be reanalyzed and in some cases individual specialties must be restudied with the improved methodology."

"The major methodological improvements needed are a better method for estimating pre - and postservice work (or directly estimating total work), and improving and validating the method for extrapolating from estimated services and procedures to all physician services. In addition, applying the methodology in Phase II should include several other improvements, such as more crosslinks for some of the specialties, more clearly defined vignettes, and better instructions to physicians surveyed in order to be sure that each is qualified to provide estimates for the surveyed services."

AUA urges Congress to allow those efforts to go forward before deciding on the utility of this particular method of determining Medicare reimbursement to physicians. It appears that eight of the eighteen medical specialties reviewed in Phase I of the Hsiao study may be reanalyzed (dermatology, psychiatry, thoracic surgery, pathology, orthopeadics, internal medicine, ophthalmology, and general surgery). That fact alone should argue strongly for delay in adopting the new fee schedule.

Medicare now operates with a fee schedule for each physician, based on the charge history each physician has established. PPRC proposes moving from a highly individualistic set of fee schedules to a national Medicare fee schedule. The primary basis would be resource costs, not charges. Congress must decide if moving to this national fee schedule would lead to

program improvements. However, a new fee schedule is just as likely to introduce problems into the payment system as did the current process. We can all acknowledge that the way Medicare reimbursement is now determined is not perfect; however, we would be naive if we assumed that a new system, whatever its basis, would not have its own set of unintended consequences. With that in mind, we must urge great caution in the Congressional consideration of these proposals to dramatically alter the current system and redistribute physician income using a public utility model.

Impact of Payment Cuts on Urologic Care

There is a consideration specific to urology which we think Congress needs to look at very carefully. PPRC suggests that transurethral resection of the prostate (TURP) reimbursement from Medicare would decline an average of 18% if the recommended fee schedule is adopted. Current budget proposals would also reduce payment for TURP.

TURP is a major surgical procedure for urologists. It makes up a large part of their surgical case load and is an important revenue generator for the urologist. Urology is a narrow specialty. That is, there are relatively few procedures and services that urologists provide to patients when compared to other medical specialties. If payment is cut for one procedure in

another broader specialty, those physicians may be able to absorb that cut more easily and minimize some of the impact. The urologist, on the other hand, does not have the breadth of procedures and the dislocation can be magnified.

A recent study of Connecticut Medicare claims data for 1986 indicates that Medicare payment for TURP is 36% of the total Medicare revenue for urologists in that state. The 1987 study of urologists nationwide demonstrated similar levels of revenue from this procedure. That means that the degree of dependence on TURP is high and changes in payment are keenly felt. This reinforces the fact that a substantial reduction in payment for TURP would have a disproportionate impact on urology. This loss may or may not be offset by other payment charges.

The chief concern of Congress for the Medicare program must be to assure that program beneficiaries continue to have access to important health care services. Over the last decade, the number of urologists around the country has increased. This is fully documented in manpower studies conducted by AUA in 1975 and 1985. The impact of this growth is an increase in the ratio of urologists to population and a dispersion of urologists out of metropolitan areas and tertiary care centers into smaller communities and their hospitals. What this means for Medicare patients is that urologic services are more readily available close to home than they once were.

However, erosion of Medicare payment could have the effect of erasing these gains in the distribution of urologic care. Often payments are already lower in those non-metropolitan areas and further cuts could be very disruptive.

Resource Cost Analysis

AUA questions whether or not resource costs should be the primary basis for determining Medicare payment. Even conceding that there are some inappropriate disparities in the payment for different kinds of services, the science of analyzing resource costs is so new that we have little confidence that consistent and usable results can be obtained.

It is instructive to examine urology's own experience with the measurement and comparison of resource values.

In 1987 Congress reduced payment for a number of surgical and diagnostic procedures, including TURP. AUA argued at the time that TURP was not over-valued. We felt that the only reason for including TURP was the fact that it is the second most common surgical procedure under Medicare. In the absence of an alternative to care for prostatic enlargement and its symptoms, TURP will continue to be a high volume Medicare procedure because the condition that it successfully treats is one that occurs

commonly among older men.

TURP is now subject to pre-admission review by PROs throughout the Medicare program. If the 1987 volume of 255,471 procedures is inappropriate, this intensive PRO review will reduce it. According to a recent study, this volume has remained stable for several years. Pre-surgery PRO review is preferable to arbitrary reductions in payment which are unrelated to improved patient care.

Since 1987, more data on TURP has become available. An independent, nationwide study of urology practice completed in late 1987 is the source of this new information about TURP and other aspects of urologic care. Based on that information, we reaffirm our belief that Medicare payment for TURP is appropriate. We also know that Medicare payments are usually 20% less than payments of private payors for the same surgery.

There are several reasons why AUA feels that TURP is not "over-valued". First, the 1987 survey of practicing urologists asked them to assign relative values to a series of urologic procedures. The survey sample was over 20 times larger than the one used by William Hsiao and the Harvard research team to develop its relative values for urology. The large sample of urologists gave TURP a higher relative value than did Dr. Hsiao in either his 1985 or his 1988 analysis.

Dr. Hsiao has now finished Phase I of his work and we have seen a variety of views on the relative value of TURP. Since 1986, it has been suggested that TURP is over-valued by 40%, 18%, and 36%; that its relative value is close to the Medicare charge level; that it may be under-valued slightly; and that it may be under-valued substantially.

The point is not that the AUA survey was right or that Dr. Hsiao was wrong, but that determining relative values can be a difficult undertaking. This is amply demonstrated by the variation in the results of the different analyses done on TURP.

Another reason why TURP should not be considered an "over-valued procedure" is found in Dr. Hsiao's own work. He published his initial results in the Journal of the American Medical Association of October 28 (Volume 260, No. 16) looking at the potential effects of a resource-based relative value scale (RB-RVS). On pages 2431 and 2432 he included a table (table 2) which compared 1986 Medicare mean charges (mean submitted charges in 1986) with the RBRVs for the services of many medical specialties, including urology. He concluded that the relative value for TURP was 1,433 and the 1986 Medicare mean charge was $1,412. Dr. Hsiao then noted the following: "Table 2 presents the RBRVs for four selected services in 18 specialties and compares them with 1986 mean charges submitted to Medicare.

These data are presented to enable physicians and reimbursement experts to assess for themselves the reasonableness of the RBRVs and to see how they differ from the current charges."

Dr. Hsiao further notes in the same article "as Table 2 shows, the ratios of Medicare charges to RBRVs vary widely, from 0.16 to 1.62. In other words, current charges do not consistently reflect the resource cost of services." However the resource cost of a TURP was extremely close to the current charges. Can we then conclude that current charges for TURP "consistently reflect the resource cost of services"? If so, then how can it be argued that TURP is over-valued by Medicare? It is only by applying a "budget neutral" control to the analysis that Dr. Hsiao and PPRC concluded that TURP is overvalued (by very different amounts).

Another reason why AUA feels that TURP should not be considered overvalued by Congress is that the comparison of Medicare charges and relative values is generally a comparison of apples and oranges. Medicare payment usually reflects the bundle of surgical services--all the things both before and after the operation, both in and out of the hospital, that the surgeon includes in the fee to the patient. From the 1987 study of urology, AUA has a good understanding of the surgical bundle for TURP. Thus we know that the single Medicare payment reflects a number of individual services and visits. The measurement of

TURP by Dr. Hsiao and PPRC does not reflect all of those inputs. In fact, PPRC is working on a model definition of the surgical bundle for all surgery to insure that meaningful comparisons can be made. That work is not complete. What this means is that these relative values measure only part of the surgical bundle, whereas the payment measures the whole bundle.

Finally, we believe comparisons of one service to another, for example, a TURP to an office visit, are premature because the contents of each package are poorly defined. PPRC acknowledges that much work needs to be done on evaluation and management services and codes in order to arrive at common understandings of the nature of each service. The redistribution effects of the proposed fee schedule depend on comparisons of relative values, yet neither the evaluation and management issues are resolved nor are the surgical bundles fully developed.

Until work is finished on these important technical questions, AUA believes no fee schedule based on relative values should be installed in Medicare. We also believe that it is inappropriate to use this incomplete analytical tool to justify substantial reduction in reimbursement for services at this time.

PPRC cites the need to monitor the impact of the new fee schedule if its recommendations are adopted by Congress. This suggests a degree of uncertainty about the proposals which we

find very troublesome. AUA believes it would be better for Congress to test the recommendations in demonstration projects or in regional trials to see if they work as intended. We think pre-testing, rather than after-the-fact testing, is the way to proceed with this new program. We believe that many of the impacts of such a system cannot fully be appreciated in advance, regardless of the skill of the simulators; therefore, we urge demonstration projects before adoption of this or any other new national fee schedule.

The PPRC proposes major redistributions in physician payment. Not only would payments move from procedures to evaluation and management services, but geographic distribution would also change. This is confirmed by the just released impact analysis of the Health Care Financing Administration. Before Congress accepts it, some testing should be undertaken to try to avoid unintended, negative consequences.

Other PPRC Issues

We agree with the Commission that any fee schedule should incorporate practice costs calculated separately. However, the index used should not average costs in such a way that many physicians will not recoup their real costs-of-practice because they don't meet some "average" definition. Practice costs might have to be figured more on an individual basis in order that

physicians be treated fairly in all parts of the country. The cost of living, as well as the cost-of-practice, may need to be examined in order to assure payment equity among physicians. Some payments in certain geographic areas are badly in need of upward adjustment; however, cost-of-living differences are real and important and cannot be ignored. PPRC's simulations suggest that surgeons in large cities could have their Medicare income reduced by 25%. Such a conclusion disregards the realities of living many people face in those areas. Other professions may adjust their fees to reflect cost-of-living. Why should physicians be singled out for this unfair treatment?

We are disappointed that the Commission does not want to include a factor for additional specialty training because we think that specialized training is an important component of the service that the patient receives. We do not believe that simply because two different kinds of physicians use the same service code means the patient has received the same service. There are efficiencies, economies and intensities that a specialized physician brings to a service that should be accommodated in any payment structure.

This failure to recognize and encourage training and excellence is disturbing. AUA is concerned that it sends the wrong signal to young people interested in medicine as a career. While monetary rewards are not the only incentive, they are

important if we are to encourage bright people to study for years, while deferring earnings, in order to take up careers that expose them to great liability risks.

The AUA is working with PPRC on the definitions for evaluation and management services, as well as on the global surgery package. We believe that PPRC has done some excellent work in this area. Because work on these definitions is not finished, it is very difficult to make comparisons between evaluation and management services and surgery. Therefore, we think those comparisons should await a standardized set of definitions, which is the object of this effort. Until everyone is speaking the same language, comparisons will be relatively meaningless.

PPRC has recommended that there be a limit on balance billing on all unassigned claims. The American Urological Association objects to that proposal, preferring that the balance billing limits be associated with the income levels of beneficiaries. AUA believes that mandatory assignment should apply to low income Medicare beneficiaries. On the other hand, we see no reason why physicians, non-Medicare patients and taxpayers should have to subsidize the cost of medical care for those Medicare beneficiaries who are perfectly capable of paying the charges in full.

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EXPENDITURE TARGETS

The most controversial part of the PPRC recommendations is the national expenditure target for physician services. While we recognize the difficulty of dealing with the current budget situation, we do not believe that an arbitrary expenditure target or budget ceiling is the way to proceed. AUA thinks it will lead to rationing of care. In those nations where targets have been put in place some patients have eventually experienced long waiting lines or denial of certain kinds of care as the full impact of the limits are felt. We do not believe that is an acceptable proposal for the American public, particularly the elderly. We believe that Congress should reject the recommendation for expenditure targets for physician services. There are other approaches to volume issues that encourage good medicine. These should be examined before adopting arbitrary spending limits. In the near term, budget savings can be found by freezing payments or taking small reductions from all payments.

Recognizing that program growth is a serious concern and also believing that physicians have a responsibility to help deal with those problems, we urge Congress to work with the physician community to develop guidelines for medical care. There is no question that medical uncertainty causes some inappropriate utilization. When the physician community can reach a consensus,

inappropriate utilization can be curtailed. We think that medically derived guidelines for care are a far better approach to dealing with program growth.

As part of the development of these guidelines, we urge Congress to create an environment in which physician organizations feel free to develop and publicize these standards. Many physician organizations are now concerned that, if they are aggressive about doing this, they will run afoul of the Federal Trade Commission or the Anti-trust Division of the Justice Department. We believe that Congress should establish a mechanism to allow the physician community to work with other public interests to develop effective guidelines for care that will curb inappropriate utilization.

Medical care is sufficiently complex to require that the physicians who perform the services be the ones most involved in the development of standards of care. It simply cannot be done by those who are unfamiliar with the particular services in question. Do not assume that all physicians know all things about all medical practice. This means that AUA and urologists should develop the standards for urologic care. In fact, AUA has established a clinical practice committee to expedite this process. Other specialists should examine their own fields. These standards should then be carefully reviewed by other groups before adoption.

AUA first developed urologic care guidelines in 1974. Updated regularly, these are designed to assist physicians provide optimum urologic care to patients. Working from this experience, we now prepare guidelines for use by payors, peer review organizations and other non-urologists with health care management responsibilities.

We intend to expedite our work. Already guidelines for TURP and trans-rectal ultrasound have been developed and made available to PROs. Other major urologic services will be addressed next.

AUA offers its expertise to the federal government to develop these guidelines now. Other specialties, both medical and surgical, should do likewise without delay.

Part of this activity should be a strengthened research effort examining the effectiveness of various medical practices. We are encouraged that Congress is moving in this area.

An example of what needs to be done is the joint effort by AUA and John Wennberg, M.D. to examine prospectively several alternative treatments for prostatic enlargement. Prompted by Dr. Wennberg's recent findings suggesting that TURP patients may have an elevated risk of death, particularly heart failure, over

a 5-8 year period after surgery, AUA asked him to join in a major international prospective study of TURP and open prostatectomy. This important project will also prospectively evaluate other emerging treatments for prostatic enlargement. This may well be the first such study of an important Medicare procedure. It is an ambitious undertaking and we invite the participation of the federal government. Federal funds supporting this research will allow it to move forward rapidly. It will also provide the government an opportunity to review first hand a major outcomes research study.

AUA is excited about working with Dr. Wennberg. A meeting will be held Saturday to develop the protocol for the study.

In conclusion Mr. Chairman, let me congratulate the Physician Payment Review Commission and its staff for the extensiveness of its analysis and the willingness of the Commission to try to accommodate many important needs and concerns. We believe, as PPRC apparently does, that a great deal more work needs to be done on the design of a new fee schedule for Medicare. We hope that you will also recognize that need and allow more work to go forward before you act to put such a program in place.

Mr. Chairman, this completes my statement and I would be pleased to answer any questions that the Subcommittee may have.

Mr. WAXMAN. Thank you very much, although Mr. Slattery was talking about flying in from Los Angeles to Kansas.

Dr. Boyle, you seem confident that we know enough to begin preliminary implementation of the RBRVS as early as next year, although I note that you did say it required a few refinements. Could you tell us what refinements you think are necessary before we get started?

Mr. BOYLE. There are a number of these already in process, Mr. Chairman. First of all, the Harvard study group is working on an evaluation of other specialties in which a report will be available in the fall. Second, there are a number of folks that are working on better evaluation of actual practice costs. There are several studies that are underway by PPRC in looking at CPT codes and a number of other factors.

However, if one assumes that the basic methodology of assigning relative values to all physician services is correct, and if the fundamental methodology that Dr. Hsiao and his coworkers developed, and as refined by PPRC, is valued—as seems to be generally accepted by all but a very few—then all you're talking about is putting different numbers into different slots. It does not in any way begin to alter a great deal of how you go about constructing such a relative value scale.

One point that sometimes is lost sight of in some of these discussions is that within certain specialties there may be some disagreement about the relative work, intensity, risk, all these factors that may go into one procedure as compared to another. Those kinds of amendments are relatively easy to correct with those kinds of professional expert advice.

Second, there appears to be some confusion when, as Dr. Ebert says, relative value, relative to what? That is precisely the point. The American College of Radiology believes that they have developed what for radiology is an appropriate relative value scale. Ultimately, that is going to have to be evaluated relative to other services if you're going to go about constructing an equitable payment system.

Since you're talking about implementing something over a period of years, inasmuch as it's going to take the Health Care Financing Administration at least a year once they are told that they have to do it, to finally come down with a system to put it in place, it would appear to us that the Congress has absolutely no reason whatsoever not to say, this year, we are going to adopt the use of an RBRVS based fee schedule, go do it.

Mr. WAXMAN. Thank you very much.

As with previous physician organizations, I appreciate your comments and support of outcomes research and practice guidelines as well as your concerns about expenditure targets and look forward to working with you on those issues.

Dr. Ebert, I like your support for the use of practice guidelines in eliminating inappropriate care. As a practical matter, how long do you think it will take for the development of a significant number of useful guidelines?

Mr. EBERT. I don't think that is a very lengthy process, Mr. Chairman. I think all the surgical specialty organizations—I think a lot of it is finance, and different ones feel differently as to how

much they independently can put into this, but I don't think time is a major factor.

Mr. WAXMAN. I want to understand better your proposal for a blended rate which includes both practice costs and demand side factors. How can we determine and measure what these demand side factors are where we, of necessity, have to rely on physician charges, and it seems to me it will be virtually impossible to reach agreement on a more direct measurement of the quality or patient preference.

Mr. EBERT. I think the charge-based system does have some reflection, obviously, over time as to what the demand portion was and let people value their services.

Remember that consensus type of development is essentially what Dr. Hsiao uses for the resources input, and I don't see that that is an unrealistic way to ask beneficiaries or the profession to look at the demand side. You could tie it in with charge bases as well and see whether charge-based seems to be unreasonable for what the worth of that particular procedure is.

Mr. WAXMAN. Dr. Rogers, I am primarily interested in the process that you went through in developing the radiology fee schedule and whether that is a process that can effectively be built into the broader reform initiative. It is probably not possible or appropriate to try to survey hundreds of procedures, so we need some way of determining values for the procedures that are not surveyed.

Based on your experience, would it make sense to use negotiations to derive these values?

Mr. ROGERS. I would like to ask Dr. Moorefield to answer that.

Mr. WAXMAN. Sure.

Mr. MOOREFIELD. The process we used, in actual fact, we did survey 740 procedures from the radiology schedule and surveyed 3,500 radiology practices in the United States. We got 2,000. We did this over several months time and then analyzed the data and produced a working relative value scale. I think it could be done. I think it makes a lot of sense for the specialty to have a big hand in determining what these relative values are rather than putting it into a system that does not address all the issues that come up in determining values.

For example, radiology is something that, the demand that is created for it comes largely from other specialties. We don't create our own demand, but we have been very successful in answering and giving information to other specialties. We don't think the Harvard type of thing addresses this, and we think that is a severe shortcoming and why we favor our method.

I understand your question. I think it can be done in a short period of time.

Mr. WAXMAN. Thank you.

Dr. Bishop, you expressed reservations about our starting to implement RBRVS at this time since emergency services, among others, have not been surveyed. However, I wonder whether you might not find it advantageous if we were to begin implementation along the lines suggested by the PPRC—namely, to use RBRVS to make marginal adjustments in the current payment rates.

I assume emergency services would be included in the category of evaluation and management services and would receive an in-

crease under this approach. Although we would not know exactly how much the eventual increase would be for these and other E&M services, we would be moving in the right direction. The only thing we would need to worry about would be whether we have overshot the mark and would have to make a later reduction to correct it. I gather you don't think that is likely to happen. Do you think this approach is reasonable?

Mr. BISHOP. We don't think it is likely to happen. I think our concern is that we truly don't know what is going to happen since we have not been studied by Harvard.

Second, in most carriers there is not a separate category defining emergency medicine as a specialty. We are either under family practice, general practice, sometimes under internal medicine, sometimes under surgery, sometimes we are placed in various areas by the carriers. So it is very difficult to pull us out and say, well, this is where we are right here.

We would agree that what you are saying is reasonably possible, that because 75 percent of what we do is really in evaluation and management and only about 20 or 25 percent in the procedure area, what you are saying is reasonably possible.

Mr. WAXMAN. Dr. Holtgrewe, you mentioned your concerns about reductions in payments for the TURP procedure since it is such a significant proportion of the urologist's practice. At the same time, you indicated your support for guidelines on the appropriateness of the procedure, for which I commend you.

My question, however, is whether your concerns about the impact on the urologist's practice would carry over and will influence your views on the development and operation of guidelines on appropriateness. Won't you have concerns about fewer services that parallel your concerns about lower fees?

Mr. HOLTEGREWE. If the number of TURP's is reduced by other alternative methods of therapy—and I might at this point add that that is very imminent—there are a number of drugs that are being tested at this time that may well have a medical impact on this disease. If that comes about, so be it. We certainly would accept that and, indeed, herald it from the point of view of the patient.

What I see as a concern is that an arbitrary reduction in TURP is carried out simply because it is the second most costly operation under Medicare, not that it is overvalued. In fact, the American Urological Association had an independent survey of our members 1½ years ago in which we asked them a variety of questions concerning their practice in general and TURP in particular, and we found that their view of the value of this—and this, by the way, included professors of urology who are on salary, who had no particular axe to grind—they all agreed that the procedure is rather fairly valued. In Dr. Hsiao's original numbers that he published in the New England Journal of Medicine last October, it agreed very closely to the numbers that we had from our national survey.

If a procedure like this that constitutes such an enormous percentage of our buffet of activities is arbitrarily slashed just to achieve economic gain for the government, my fear is that it will disrupt the availability of urological care in rural America, it really will.

The man in retention who the family physician or the general surgeon cannot catheterize has a long way to go from Hayes, KS, to Kansas City or to Denver. It is 2 hours or 2—or 10 hours may seem like 10 months.

So I think that our concern is that we don't disjoint the system by prematurely and precipitously jumping on some system, be it across-the-board cuts or be it an RBRVS. We understand that there are going to be demographic changes in our practice that are inevitable, and we are willing to accept that.

We are particularly vulnerably in urology because of the abundance of our dependence on one operation.

Mr. WAXMAN. Thank you.

Mr. Walgren.

Mr. WALGREN. Thank you, Mr. Chairman.

Dr. Ebert, you emphasize in your statement the problem of volume and increasing volume, and the question is whether surgeons can reduce volume, control volume. Some argue that they are basically responding to patient referrals. How do you feel surgeons—how effective would they be in trying to reduce volume, and how would they do it?

Mr. EBERT. I don't think we are implying that the surgeons in our proposal are going to reduce volume. What we are saying is, we would like to stabilize the dollars spent for surgical services, because we don't think volume is expanding in surgery at the same rate that it does in some other aspects of medicine, and thus I don't think there is any intent to say we are going to do less. I think if things are inappropriate and defined by guidelines or by regional differences, or whatever, that they are inappropriate, then they should be looked at.

We are concerned about volume. We are also concerned very much—and it was mentioned earlier today about the problems of access to the patient and the difficulty the doctor has in getting a patient in for an operation. We are a great believer that if guidelines are employed, they should look more at the spectrum of the surgeon's practice, and if he is doing a large number of procedures that seem inappropriate as compared to his peers, that then the profession should be willing to look at those. I don't think it is a volume reduction system except for areas where inappropriateness would be.

Mr. WALGREN. But you said there that the basic thrust of the surgery specific proposal for a category, I guess, would be to maintain the present participation in terms of percentage of medical expenses that go to surgery.

Mr. EBERT. Yes, that is correct. What we are saying is that there is a target that surgery services are identified today; it is about 30 percent of the Medicare budget. We also believe that the majority of guidelines and criteria set for admission to a hospital are all developed within surgery. The quality assurance program is already developed in it. We don't see a reason that that should have unreasonable expansion, and if it does, then we think the surgery profession should be willing to accept reductions in its conversion factor if it can't, so to speak, predict.

Mr. WALGREN. But if it is a percentage of the whole, and as we go forward we change the weight of practice and we expand pri-

mary care, how could the surgeon say at that point that they should occupy 30 percent without question?

Mr. EBERT. I don't know that he would necessarily say you are occupying 30 percent. If you decide to expand primary care, I think what you are looking at is a budget neutral redistribution. I interpreted that in the comment you made.

I would also comment that a lot is said about the Canadian system, about standing in line and waiting for services. They are not standing in line for primary care services. It is hospital admissions that get hit the hardest any time there is any reduction, and we are saying maybe there should be some effort made to protect that aspect since it has been fairly well developed, and we don't think that volume will increase or inappropriateness is as easy to occur in an inpatient system or ambulatory care center where surgery is performed since we have much better quality assurance measures already in place.

Mr. WALGREN. But the budget neutral aspect of your proposal would be essentially to lock in a percentage of the medical care dollar in surgery. Would that be the function of that?

Mr. EBERT. I think what you are saying is, you put a target out there and say this is what you paid this year for surgical services. If the appropriateness is considered in that package to be reasonable, you should then take into account in a predictable fashion how much you think it has got to increase in cost of practice, or whatever, for a year from now and also how many aged people are likely to—it may go down, as Dr. Holtgrewe says. You may find a drug that eliminates an operation, but we believe right now it is all retrospective budgeting. It is, come in now at the last minute and then say, "What can we reduce this year?" We say it might be time to look ahead and say, "Isn't it predictable to put something out there and see if we can't live within it?"

Mr. WALGREN. I guess what interests me is that it seems that you are suggesting that we set aside a certain percentage for surgery based on present practice, and then you are willing to take an expenditure target based on that setaside.

The other parts of the medical profession seem much more wary of the expenditure target, and they are concerned that you would get direct rationing under an expenditure target and pressure to reduce services by individual physicians in a way that only some appropriate services would be denied or moved away from by that practicing physician, and yet that is not a concern in your area, and it seems striking in contrast.

Mr. EBERT. I think it is a difference in interpretation of the words "target" and a "cap." If you put a cap on something and say we are only going to spend x amount of dollars, and when we reach that point we are not going to go any further, that is a rationing system. I don't see that there is any correlation between really prospective budgeting. That is what this has really looked at. I don't see any rationalization there between rationing of services and the fact that we are saying, "Predict ahead of time one year what you think that program should be worth or should cost." That is a long way from rationing in my book. If you make it to a cap, that is a congressional decision. You will probably do that anyway if you

choose to go that route. But I don't think that is at all what we are proposing.

Mr. WALGREN. I just wanted to highlight what I thought was particularly good language on the expenditure target in the statement by Dr. Boyle on page 11, Mr. Chairman. I thought it was very well put. My memory did not quite get to that in the formal presentation, but the language there is strong and communicates very directly about expenditure targets.

I wanted to give the gentleman from radiology a chance to make any concluding comments that he would like to make.

Is there something, a red flag, that you would like to fly that you didn't get a chance to?

Mr. ROGERS. I would like to reiterate—well, not because of its importance, but we have identified and verified substantial geographic variations in reimbursement patterns for radiologic services which I would share with you. The lowest in the country is in Kansas, strangely enough. Mr. Slattery was right. It was $7.89. The highest in the country was in Illinois and, I would hasten to add, not in my locality. It was $18.85 for the similar services. So we have a 2.5 difference in reimbursement for the same services that defies explanation.

I would also like to call to your attention the problems, again, that the carriers have found it exceedingly difficult, for whatever reason, to identify with accuracy expenditures for radiologic reimbursement during the base period of 1987/88. Their data base is not as accurate or complete as one might presume, and the difficulties encountered in the extraction of the necessary information from the data base far exceeded what was expected.

The implications of this experience for the broader implementation of a relative value scale for other—all physician services are of obvious importance. The implementation of any fee schedule based on past expenditures will most assuredly encounter similar problems, which you should be aware of.

I thank you.

Mr. WALGREN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Walgren, and thank you, gentlemen, for your presentation. We are looking forward to working with you on this legislation.

That concludes our business for today. We stand adjourned.

[Whereupon, at 12:35 p.m., the hearing was adjourned.]

[The following statements were submitted for the record:]

Statement

of the

AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Mr. Chairman and members of the Sub-Committee, I am Newton C. McCollough, III, M.D., President of the American Academy of Orthopaedic Surgeons, Director of Medical Services for Shriners Hospitals for Crippled Children, and a professor of orthopaedic surgery at the University of South Florida.

The American Academy of Orthopaedic Surgeons appreciates the opportunity to comment on various physician reimbursement issues before Congress.

The Academy shares the concerns of the public and the Federal government about the rising costs of health care in America, and wants to participate actively in developing effective cost-containment strategies. However, we recognize that these strategies must be developed and implemented in a way which does not compromise the quality of health care.

In our testimony today, we wish to discuss the following issues:

1. The Proposed Resource-Based Relative Value Scale;
2. The Implementation Period for a New Medicare Fee Schedule;
3. Professional Liability Expenses in Relation to Medical Practice Costs and Physician Fees;
4. Physician Acceptance of Medicare Assignment for Low-Income Families;
5. Improving the Standardization of Coding and Billing Practices;
6. The Possible Use of Medicare Expenditure Targets; and
7. Identification and Elimination of Ineffective and Inappropriate Medical Practices.

1. The Proposed Resource-Based Relative Value Scale (RBRVS)

We believe that the proposed RBRVS seriously misrepresents the value of orthopaedic services relative to other medical services. Furthermore, the RBRVS will not address the concerns of the medical profession and the Federal government about increasing health care costs, since it does not address the issue of volume control.

In addition to having serious methodological flaws, the RBRVS fails to consider important factors such as the severity and complexity of the patient's condition and the benefit/outcome (value) which the service provides to the patient. The Medicare fee schedule should be based on a substantially revised relative value scale, based on more accurately calculated resource costs, blended with historical fee data to provide an index of value.

Medicine and surgery are not industrial/production line activities. The art of medicine and the skill required to perform a service are not easily quantified as resources. The proposed RBRVS would shift billions of dollars from surgical care, where curative and restorative outcomes are clear, in order to increase the compensation for millions of encounters and services where volume constraints are not established by current methods and where the skills employed and patient benefits to be obtained are much more difficult to document.

We believe that the RBRVS is flawed in two major ways. First, the methodology for calculating the resource-inputs has serious shortcomings. Revisions are required, including:

o Pre- and post-service time estimates have methodological weaknesses and need further study;

o Cross-specialty links for orthopaedics often were not as successful as for other specialties; they need to be re-examined and possibly broadened;

o The vignettes used in orthopaedics may not be representative of the full range of services provided by the specialty and should be re-examined and revised;

o The extrapolation methodology used to project the surveyed services to non-surveyed services produced mixed results as seen in a comparison of the American Medical Association data and the Harvard study data, and must be carefully analyzed.

A second major flaw is that basing the relative value scale strictly on resource inputs overlooks many important factors contributing to the value of a given service, such as its value to the patient or the quality of the service provided. Recognizing that these factors are not yet sufficiently developed to use in a fee schedule, we support a blended relative value scale, based on an improved RBRVS together with existing physician charges, used as a rough approximation of the value of services to the consumer.

2. The Implementation Period for a New Medicare Fee Schedule

We urge a gradual implementation of the new Medicare fee schedule. The two-year implementation period proposed by the Physician Payment Review Commission (PPRC) is not long enough to accomplish the necessary revisions or to accommodate the serious impact on many orthopaedic practices that will result if we are subjected to payment cuts of up to 72 percent for some procedures.

The Academy has recently reviewed a procedure-by-procedure description of the impact of the proposed RBRVS on orthopaedics. The impact is staggering, with reduced payments ranging from 30-72 percent for many common orthopaedic procedures. This degree of reduction could have a significant impact on our continued ability to treat the uninsured patients who need and deserve attention. Our recent practice survey indicates that over 70 percent of orthopaedic surgeons regularly provide care for patients from whom they neither expect nor receive compensation.

In order to avoid a catastrophic impact on the organization and viability of thousands of orthopaedic practices, their employees, and the availability of community services, we recommend a much longer phase-in period than the PPRC's two-year period. A gradual implementation period will permit necessary practice reorientation and staffing adjustments.

3. Professional Liability Expenses in Relation to Medical Practice Costs and Physician Fees

We believe that any new Medicare fee schedule should treat professional liability expenses as a separate item when determining practice costs as recommended by the PPRC, recognizing regional and specialty variations and the need for frequent updating.

Furthermore, it is our opinion that Federal initiatives to resolve the professional liability problem could result in substantial savings for Medicare and reduce the adverse impact of the proposed fee schedules on high risk specialties.

Given the volatility of the professional liability situation, we believe that any new fee structure must be extremely sensitive to the impact of professional liability insurance premiums on practice costs and physician fees. Expenses vary widely by geographic area, by specialty, and from year-to-year.

4. Physician Acceptance of Medicare Assignment for Low-Income Families

The Academy supports the concept of physician acceptance of assignment for low-income families. Over 53 percent of orthopaedic surgeons now participate in the Medicare program, and 91 percent of non-participating orthopaedists accept assignment on a case-by-case basis.

Like Congress, the Academy has a real concern for needy elderly patients and believes that the profession should express its willingness to accept assignment for patients with low income levels as we orthopaedists are already doing.

5. Improving the Standardization of Coding and Billing Practices

We support improved standardization of coding and billing practices, and we are working on defining the content of the PPRC's uniform global fee definition for orthopaedic surgical procedures.

Because individual Medicare carriers have different coding and billing policies, wide inconsistencies exist in coding and billing practices. We believe uniform policies could eventually help reduce Medicare expenditures, as well as the likelihood of abuse. To further these objectives, we also believe that the uniform global fee concept should be expanded to include procedures performed by non-surgical specialties as well.

6. The Possible Use of Medicare Expenditure Targets

The Academy cannot support the concept of expenditure targets at this time. We believe that extended and careful study of the concept needs to be undertaken to explore the potential impact on patient care and access and to assess whether sufficient data is available to establish targets. If expenditure targets are implemented in the future, separate targets should be used for surgical services as distinct from other services.

7. Identification and Elimination of Ineffective and Inappropriate Medical Practices

An alternative to expenditure targets as a way of controlling the volume of Medicare services is to begin identifying and eliminating ineffective and inappropriate medical practices. While methods to do this are in their infancy, many fledgling projects are underway. These projects, including practice guidelines, small-area variation studies, outcome studies, and technology assessment, would benefit from vigorous support by the Federal government and the private sector. We see this as the most rational approach to dealing with the volume of services issue from the provider standpoint.

Another approach to address burgeoning health care costs is to begin efforts to moderate the volume of services being demanded by the public. To continually restrict resources available to hospitals and providers without moderating demand for services will ultimately lead to a destruction of the finest health care delivery system in the world. Difficult as it may be, you must exert leadership and assist us in addressing the public and its demand for ever-increasing benefits coupled with its unwillingness to pay the reasonable cost of the services it desires.

Top 36 Medicare Expenditures

As a final point Mr. Chairman, we recently reviewed 1987 Health Care Finance Administration (HCFA) data on allowed services and allowed charges (See Attachment). Of the top 36 most costly services, six, totaling $2.9 billion for 120.4 million units of service, were for follow-up office or hospital visits designated as limited, brief, or intermediate. These are the same areas targeted for substantial increases without corresponding volume controls. We believe this large volume of services and expenditures should be evaluated for content, need and effectiveness. The Congress, the Administration, and Medicine must develop mechanisms to determine if the Medicare patient is receiving a health benefit equal to the public dollar spent.

We believe that the Congress must ask what factors truly make a difference in longevity and quality of life for our senior citizens. A timely evaluation of Medicare services is essential to determine if all of the billions of dollars being spent are for services and procedures of significant value to the patient. The Academy stands ready to assist in this type of endeavor.

We appreciate the opportunity to express our view on these physician reimbursement issues, and we look forward to continuing to work with you on these and other vital health care concerns.

ATTACHMENT

MEDICARE EXPENDITURES FOR 36 MOST FREQUENT PRACTITIONER SERVICES

Procedure Code	Description	Allowed Services	Allowed Charges
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or phacoemulsification technique	1,030,410	$1,505,453,494
90060	Office Medical Service, new patient; intermediate service	40,956,607	$1,034,712,140
90260	Subsequent Hospital Care each day; intermediate services	29,772,656	$ 878,984,597
90050	Office Medical Service, established patient; limited service	42,205,886	$ 858,929,877
90250	Subsequent hospital care, each day; limited services	23,514,348	$ 604,370,681
90620	Initial consultation; comprehensive	4,929,576	$ 447,901,822
90220	Comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	5,672,370	$ 437,393,921
93000	Electrocardiogram, routine EGB with at least 12 leads; with interpretation and report	9,610,604	$ 329,627,435
71020	Radiologic examination, chest, two views, frontal and lateral;	14,641,479	$ 318,617,533
52601	Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	255,471	$ 287,144,256
90070	Office Medical Service, established patient; extended service	8,615,177	$ 283,206,862
90270	Subsequent hospital services, each day; extended services	6,902,831	$ 267,586,089
90040	Office medical service, established patient; brief service	13,042,378	$ 222,178,650
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	16,505,729	$ 205,086,593
90080	Office medical service, established patient; comprehensive service	3,972.191	$ 190,176,015
90020	Office medical service, new patient; comprehensive	3,085,313	$ 172,982,180

MEDICARE EXPENDITURES FOR 36 MOST FREQUENT PRACTITIONER SERVICES

Procedure Code	Description	Allowed Services	Allowed Charges
33512	Coronary artery bypass, autogenous graft, (eg, saphenous vein or internal mammary artery); three coronary grafts	62,762	$ 167,378,443
27130	Arthroplasty,acetabular and proximal femoral prosthetic replacement (total hip replacement)	92,100	$ 166,130,169
27447	Medial and lateral compartments with or without patella resurfacing (total knee replacement)	96,236	$ 164,982,258
71010	Radiologic examination, chest; single view, frontal	11,837,278	$ 162,455,025
90240	Subsequent hospital care each day; brief services	8,019,813	$161,632,653
92014	comprehensive, established patient, one or more visits	3,849,185	$151,264,081
90630	Initial consultation; complex	1,245,577	$ 149,800,117
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic	490,566	$ 148,898,512
33513	Coronary artery bypass, four coronary grafts	53,010	$ 148,857,926
93547	Combined left heart catheterization, selective coronary angiography, one or more coronary arteries and selective left ventricular angiography	205,079	$ 140,414,231
45378	Colonoscopy,fiberoptic, beyond splenic flexure; diagnostic procedure	328,647	$ 136,970,201
80019	Pathology and Laboratory, 19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	7,751,248	$ 135,974,256
66821	Anterior segment -- lens laser surgery (eg, YAG laser)	268,182	$ 129,736,192
45385	Endoscopy: for removal of polypoid lesion	190,565	$ 121,743,259
66983	Intracapsular cataract extraction with insertion of intraocular lens prostheeis (one stage procedure)	87,340	$ 120,975,983
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	3,899,650	$ 116,673,174

MEDICARE EXPENDITURES FOR 36 MOST FREQUENT PRACTITIONER SERVICES

Procedure Code	Description	Allowed Services	Allowed Charges
27244	Open treatment of closed or open intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture, with internal fixation	114,964	$ 116,213,249
90215	Intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records	1,817,042	$ 109,646,446
99173	Intermediate examination, evaluation and/or treatment, same or new illness	2,210,031	$ 106,790,712
90280	Subsequent hospital care; comprehensive services	2,513,618	$ 106,284,272

STATEMENT

of the

AMERICAN COLLEGE OF NUCLEAR PHYSICIANS

and

SOCIETY OF NUCLEAR MEDICINE

Mr. Chairman and Members of the Subcommittee:

The American College of Nuclear Physicians and the Society of Nuclear Medicine are pleased to submit this statement concerning physician payment reform, and in particular, the new Radiology Relative Value Scale (RVS) payment system that went into effect on April 1, 1989. The College and Society together represent roughly 4,000 physicians involved in the clinical practice of Nuclear Medicine, most of whom practice full-time in this specialty.

The College and Society recognize that the present method of paying physicians under the Medicare program is in need of reform. Although we support reform that is equitable for both physicians and patients, we are opposed to short-term, untested and unsubstantiated changes in the payment system for a select group of physicians or specialties merely to achieve budgetary savings, especially if one group is unduly penalized in relation to others.

Full-time Nuclear Medicine physicians (the roughly 3,000 doctors who spend 50 percent or more of their time in Nuclear Medicine only) are deeply concerned that the new Radiology RVS payment system does not meet the test for equitable, long-term, proven reform for physicians. The College and Society are currently surveying our members to determine the national impact of the Radiology RVS on our specialty. Although the survey is now being analyzed, reports across the country reveal that these full-time Nuclear Medicine physicians are facing cuts of 20 to 40 percent, while cuts for Radiology as a whole are less than half that magnitude. If these substantial cuts continue, then Nuclear Medicine physicians will be forced to choose between two

unacceptable alternatives: 1) continue to take Medicare patients and place their practices in fiscal jeopardy; or 2) exclude Medicare patients from their practices. Since neither of these options is acceptable, other alternatives must be created.

Nuclear Medicine is Different from Radiology

Nuclear Medicine is a distinct, separate specialty in which radioactive materials are administered to patients to diagnose and sometimes treat disease. An estimated 120 million Nuclear Medicine procedures are performed yearly in the United States; roughly one out of every three patients admitted to a hospital will receive a Nuclear Medicine study during his/her stay.

Nuclear Medicine physicians are primarily concerned with how organs function (physiology) in contrast to conventional Radiology which focuses on what structures look like (anatomy). Our physicians provide critical diagnostic information about heart disease, cancer, stroke, Alzheimer's disease, dementia, epilepsy, bone diseases and sports injuries, thyroid disease, lung diseases, AIDS, infectious diseases of unknown origin and pediatric diseases. For example, First Lady Barbara Bush recently was treated with radioiodine in a Nuclear Medicine procedure for her Grave's disease.

The specialty of Nuclear Medicine has its own medical certification board (American Board of Nuclear Medicine), its own residency training programs, and in many hospitals and clinics its own separate department. Nuclear Medicine specialists have four to eight times more Nuclear Medicine training (24 months) than general radiologists who receive their Nuclear Medicine training

in three to six months. Our specialty is recognized as distinct and independent by both the American Board of Medical Specialties and by the American Medical Association. Additionally, Harvard Professor William Hsiao and his team on the Resource-Based Relative Value Scale study recognized Nuclear Medicine as a distinct specialty when they decided not to include Nuclear Medicine as part of Radiology in the Harvard study. Nuclear Medicine is now being studied separately in the second phase of this study.

Although some radiologists do perform some Nuclear Medicine procedures, we believe full-time Nuclear Medicine specialists (most of whom are not radiologists by training), generally provide a more physician-intensive and complex service, including more interaction with patients, taking histories, conducting limited physical examinations of the organs to be imaged, extensive interaction with the technologists, and providing an interactive consulting report to the referring physicians. Additionally, Nuclear Medicine physicians have significant daily involvement in quality control activities, above and beyond those mandated by the Nuclear Regulatory Commission.

Nuclear Medicine did not Support the Radiology RVS

During deliberations over OBRA-87, the College and Society expressed concerns about the Radiology RVS as proposed by the American College of Radiology. With very few details of the proposal and strong concerns about the negative impact on our specialty, we opposed the Radiology RVS provision in the reconciliation bill, and we opposed the inclusion of Nuclear Medicine in the Radiology RVS.

The Radiology RVS was developed by the American College of Radiology and accepted by HCFA. Neither ACR nor HCFA substantially consulted with our groups or other groups during the development or application of the Radiology RVS. ACR first surveyed its own members for charges for all radiologic procedures and then created a charge-based RVS from that survey. None of these practices surveyed, by definition, were solely Nuclear Medicine practices, and therefore, the full-time Nuclear Medicine practitioner was not adequately represented in ACR's sample. Using additional magnitude estimation data and their own experience, each of the ACR's six consensus panels (of which Nuclear Medicine was one), created an experience-based RVS for the CPT codes in their category. A final steering Committee combined the values of each consensus panel, with some adjustments, into one comprehensive RVS for all radiologic CPT codes.

Radiology RVS is not Equitable for Nuclear Medicine

The Radiology RVS, as implemented by HCFA using sometimes erroneous conversion factors, has been disastrous for Nuclear Medicine, with cuts ranging from 20-40 percent, which are greater than those for any other area of Radiology. The College and Society recently commissioned their own study, which revealed that the charge data collected by ACR was not reflective of full-time Nuclear Medicine practices and therefore was unrealistically low for Nuclear Medicine procedures. Full-time Nuclear Medicine specialists tend to have higher charges than radiologists performing these procedures because, we believe, of the higher physician involvement, more complex technology, more

extensive Nuclear Medicine training, and extensive quality control activities. Because the ACR survey data did not reflect this type of intensive service, it created a systematic downward bias for Nuclear Medicine procedures.

The Radiology RVS payment system is further affected by erroneous conversion factors calculated by several Medicare carriers across the country. Although ACR is investigating "suspect" carriers to identify incorrect conversion factors, this is an extremely time-consuming and expensive process. The College and Society do not have the resources to send investigatory teams to "police" Medicare carriers, nor do we feel that medical specialty societies should be forced into this role. The entire Radiology RVS payment system has revealed numerous database problems with the carriers, which does not bode well for the adoption of conversion factors for the national Resource-Based RVS system in the coming years.

The College and Society are gravely concerned about the severe negative impact of the new Radiology RVS on the field of Nuclear Medicine. Since Nuclear Medicine represents the only large group of physicians who rely on one form of imaging for essentially their entire income, it seems inequitable that our specialty is facing greater decreases. Moreover, physicians who derive their income solely from Nuclear Medicine cannot balance off these decreases with increases in other areas such as interventional Radiology or general diagnostic radiology since they do not and cannot perform these procedures. Severe reductions in Nuclear Medicine payments will not only harm current practitioners, but will threaten the longevity and future of the field.

Nuclear Medicine Problems Require a Legislative Solution

The College and Society have shared our data and held discussions with both ACR and HCFA. ACR will not reopen the RVS to make adjustments for Nuclear Medicine, and HCFA believes that it can make very few changes for Nuclear Medicine without the consent of Congress.

We respectfully request that Congress recognize Nuclear Medicine as the distinct specialty that it is, and exempt full-time Nuclear Medicine physicians from the Radiology RVS. Instead, these physicians (less than 3,000) should be paid under their usual, customary and reasonable fees until Medicare adopts a national across-the-board fee schedule. Under this exemption, we would define full-time Nuclear Medicine physicians as those who are certified or eligible to be certified by the American Board of Nuclear Medicine or the American Board of Radiology with Special Competency in Nuclear Medicine, or those physicians for whom Nuclear Medicine services (78000 - 79000 in the CPT codes) account for at least 50 percent of the total amount of charges made by the physician for Medicare Part B services. Our physicians are ready to accept an equitable percentage reduction (such as the 3 percent mandated by Congress) in these UCR payments so that exempting Nuclear Medicine from the Radiology RVS will not have a significant budgetary impact.

The College and Society are continuing to gather data to support our exemption from the Radiology RVS, and will share it with the Subcommittee when it becomes available. We urge your consideration of our concerns and hope you will support our exemption for full-time Nuclear Medicine physicians from this inequitable payment system. We stand ready to assist this Subcommittee in this regard.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Statement of the
American Society of Anesthesiologists
on the

Resource Based Relative Value Scale
and
PPRC Report to Congress

submitted to
House Energy and Commerce Committee
Subcommittee on Health and the Environment
June 5, 1989

Representatives of ASA were active participants in the Harvard/AMA RBRVS study. ASA has serious concerns with the study, but we are supportive of the RBRVS payment methodology and have ourselves published a resource-based relative value guide (RVG) since well before the inception of Medicare.

ASA's comments are tempered by the fact that anesthesiology was not included in either the September final report from Hsiao, nor the Physician Payment Review Commission (PPRC) 1989 Report. Therefore, we do not know what reordering of anesthesia payments may eventually result. Lack of CPT coded anesthesiology claims, inadequate time data, the existence of the ASA RVG, and the unique nature of anesthesia services apparently led to the specialty's non-reported status. We will address these issues, as well as our methodological concerns.

Relative Value Guide

Anesthesiologists have been reimbursed on the basis of a relative value system since before the enactment of Medicare, and ASA published its first RVG in 1962. ASA has testified in previous years before the Committee on Finance health subcommittee regarding the RVG. We believe the Guide is so important both as the framework for budget reductions and a precursor of the Hsiao/PPRC Resource Based Relative Value Scale (RBRVS), that it is appropriate to highlight its methodology and use.

In its simplest form, the RVG is developed by assigning to each distinct surgical procedure or service a unit value, based on the complexity, effort and resources associated with the procedure. In this way, a table or scale is constructed for a series of procedures or services to which are assigned individual unit values demonstrating the relative complexity of each. These are the base units. For example, in the 1988 ASA RVG, there are 20 base units assigned to cardiac bypass grafts, compared to 4 base units for hernia repairs. Because our Guide and the related CPT-4 codes are broad (there are 250 anesthesia codes for the 6,000 surgical codes), new codes are rarely needed when new technology is introduced. This, in turn, means there are relatively few new services in anesthesiologists' reimbursement.

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Time is the essential element in determining the level of anesthesia service for each individual patient and can vary substantially according to each patient's circumstances. Because time is so essential to anesthesia practice, the ASA RVG adds time units; Medicare recognizes one unit per each fifteen minutes of anesthesia time for anesthesiologists providing care directly and one unit per each thirty minutes of anesthesia time for anesthesiologists providing medical direction services.*

Anesthesia time is defined as beginning when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ending when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision.

ASA regards the time factor as enormously important in providing a fair and accurate measurement of the anesthesiologists' services. It is the surgeon, not the anesthesiologist, who controls time. There is a high and stable correlation between surgical time and anesthesia time; operating room and recovery room records yield easy verification of anesthesia time.

I also would like to note that anesthesiologists do not charge beyond the base units for pre-operative time spent in evaluating and caring for the patient. Even though complex procedures invariably require a detailed, time-consuming pre-operative evaluation, it is still accounted for by the base units.

The ASA RVG also uses physical status modifier units to quantify the medical condition of each patient. The administration of an anesthetic to a patient with severe concomitant systemic disease simply carries a higher risk and requires greater skill than does performing the same procedure on a healthy patient. Research indicates that it is the physical status of the patient, not the surgery or anesthetic, which is the best predictor of surgical outcome.

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* Prior to implementation of a Part B payment system for certified registered nurse anesthetists (CRNAs) on March 1, 1989, Medicare recognized: one time unit per each 15 minutes of anesthesia time for anesthesiologists medically directing their employee-CRNAs; and one time unit per 30 minutes of anesthesia time for anesthesiologists medically directing hospital-employed CRNAs.

The RVG, then, describes and measures anesthesia care provided to individual patients. To establish a charge based on the RVG, a dollar conversion factor is applied. Each anesthesiologist has three conversion factors: the Medicare prevailing conversion factor, which is the amount recognized by the carriers for all anesthesiologists in an area; the discounted MAAC conversion factor, which is the individual anesthesiologist's 1984 frozen actual charge with appropriate MEI updates; and the non-discounted conversion factor charged to non-Medicare patients or commercial carriers.

The RVG methodology frequently results in "automatic" savings to the Medicare program. With improved surgical techniques and familiarity with procedures, anesthesia time is often reduced. When this happens, the number of reported time units is also reduced, automatically resulting in a reduction of the total charge, both as recognized by Medicare and to the patient. Similarly, the anesthesia risk and complexity base units may be reduced over time. A prime example of decreased charges resulting from use of the RVG is illustrated by pacemaker implantation. Previously implanted through an open chest requiring two to three hours of anesthesia time, pacemakers are now inserted through a vein in an hour or less. Because of these procedural changes, ASA reduced the base units from 20, to 15, to 4; time units decreased from 12, to 4.

The ASA RVG is not a static document, but one which is reviewed each year and, through ASA House of Delegates' action, changes are approved. The 1988 RVG reduced base units for seven procedures; none were increased. Again, when such revisions reduce base units, there are savings to the Medicare program, commercial carriers, and all patients.

OBRA 87: Uniform RVG

Although Medicare has for some years required that anesthesiologists be reimbursed using the RVG methdolology, the 54 carriers have not been required to use a specific guide. Section 4048 of the Omnibus Budget Reconciliation Act of 1987 mandated that HCFA establish a uniform RVG for reimbursement of anesthesia services under the Medicare program. Section 4048 was inserted into OBRA 87 at the urging of ASA and was strongly supported by ASA in the course of its consideration by Congress.

ASA clearly supports HCFA's proposed regulation adopting the 1988 ASA RVG and the associated CPT-4 anesthesia codes for services provided after March 1, 1989. We remain opposed to HCFA's proposal to eliminate recognition of physical status modifier units from the uniform RVG recognized by Medicare. Modifiers as measures of individual case severity are an integral part of the ASA RVG; to eliminate them is to adopt an incomplete RVG, one which in essence will distort the measurement of care rendered to many patients.

In light of the Physician Payment Review Commission's support for incorporating severity of illness measurements in the

Harvard Resource Based Relative Value Scale, and Dr. Hsiao's indication that the ASA system could be a model, HCFA's proposal does not make sense.

ASA believes a flaw of the RBRVS is that it does not measure or account for severity of illness. A physical status modifier system has proved an excellent way to achieve such a measurement and makes the RVG patient specific.

Resource Based Relative Value Scale (RBRVS)

The Subcommittee recently heard testimony from both Dr. Hsiao and Dr. Philip Lee, Chairman of the PPRC. PPRC's Annual Report to Congress presents its recommendation that an RBRVS be finalized, with phased-in implementation to begin in 1990. PPRC also recommends increased funding for the development of practice guidelines and standard setting.

With ASA's history of RVG development and the historical use of a relative value system by anesthesiologists, it is not surprising that we are strong supporters of this system. As mentioned, ASA was an active participant in the Hsiao RBRVS study and at the December 1988 AMA House of Delegates' meeting, ASA voted in support of Report AA. While ASA and others will disagree with reductions in reimbursement which could result from the RBRVS, the concept is sound and we believe its adoption likely. Implementation of the RBRVS for all of medicine would bring a dramatic change in physician reimbursement. If the Congress chooses to implement the RBRVS, then, as PPRC has noted, the cooperation of physicians will be required to make it work. ASA believes the American Medical Association must play an important role in the still-needed refinements of the RBRVS and in maintaining physician cooperation. As we seek our specific refinements, we will continue to work with Dr. Hsiao, the AMA, PPRC, and ultimately the Congress.

Certainly, we consider the ASA RVG to be the best existing measurement of anesthesia services, and are gratified that both Dr. Hsiao and PPRC agree. Hsiao indicates he has confidence in ASA's RVG, and its application of base units, time units and physical status modifiers. Indeed, Hsiao states he will "need to translate the RBRVS into the present relative value system used by [anesthesiology] and examine how the RBRVS could be implemented in the context of that existing system." He further states his methodology "is built on one designed by the ASA, which uses time and complexity measures."

Similarly, the Physician Payment Review Commission states in its recently-released report to Congress:

> For anesthesia services, most carriers have long used various versions of the Relative Value Guide developed by the American Society of Anesthesiologists. The RVG bases payment on time, the difficulty of the operation, and patient condition. OBRA 87 directed the Secretary to develop a

standard version of the RVG for use by all carriers. The policy has recently been implemented. Since the RVG is clearly resource based and has been in use for some time, the Commission plans to consider it as an alternative to the values developed by the Hsiao study for relative values among anesthesia services. The conversion factor would have to be adjusted to integrate the RVG with the rest of the RVS.

ASA will continue working with PPRC on retention of this accepted methodology within any new system.

Hsiao's RBRVS findings on the limited sampled services shows a high correlation, .96, with ASA's relative value base units and supports "the validity of the ASA approach." Apart from the base unit values, and their relationship to the RBRVS, Hsiao agrees there are special time considerations for anesthesiologists, but lacked the data necessary to extrapolate his study data in this report.

Time is not only a key element of our RVG, but one over which the anesthesiologist has no control. Previous studies related to physician DRGs undertaken by Battelle Human Affairs Research Centers and provided to the PPRC, show a high, consistent correlation between anesthesia time and surgical time (.94) for specific procedures. Ninety-one percent of the variation in time across procedures is predicted by surgical time alone.

ASA is able to compare Hsiao's intra-service time estimates with data from the Battelle study:

Procedure	Hsiao Study Time		Battelle Study Time	
	Intra	Other	Surgical	Other
CABG	260.6	113.1	272.9	105.6
Total hip replacement	181.6	86.4	161.2	68.8
Cholecystectomy	99.1	55.8	116.6	36.6
Endarectomy	132.1	68.4	156.4	46.2
TURP	82.2	49.9	65.3	33.0
Inguinal hernia repair	64.5	44.5	70.5	43.1
Open reduction and int fixation hip fx	116.3	62.5	112.2	38.9

Hsiao's pre- and post-service time are often higher than the difference between anesthesia time and surgical time in Battelle. We believe this may be explained by Hsiao's inclusion

of pre-surgical anesthesiologist visits. As noted previously, ASA does not "count" this time separately, but considers it part of the base units.

Therefore, notwithstanding the apparent agreement we have with Hsiao's measurement of anesthesiologists' intra-service work and the resulting unit values, the RBRVs by themselves are incomplete and would not be acceptable to ASA without the critical addition of time units.

For example, CPT code 31500, endotracheal intubation, is given an RBRV of 199 for a pediatrician. Does that 199 value mean to imply that the total anesthetic management of the patient undergoing a laparoscopic procedure, with an RBRV of 204, is worth only 5 units in addition to the intubation by the anesthesiologist? Obviously we think not, and believe this illustrates why actual time spent must be added to the anesthesiology RBRVs.

ASA believes any relative value system for anesthesia services must recognize actual time spent in any setting. We would support tighter definitions of fractional units, and have so indicated to both HCFA and the Office of Inspector General (OIG).

Specialty Links

As we have indicated, Hsiao's measurement of anesthesiologists' intra-service work appears accurate as to intensity, risk and cognitive value. That is, the RBRVs assigned to anesthesia procedures correlate with the base unit values of the ASA RVG. We believe the study falls down and bias enters when Hsiao extrapolates across specialties. It is unlikely that there will be much straightforward translation in the cross-specialty alignment, so it is often a process of "making things fit." The fewer the real intra-service links, the greater the potential for systematic under- or over-valuation of a specialty's services, as the entire alignment hinges on one or two actual links.

The PPRC recognizes that there are significant problems with the Hsiao cross-specialty links for several specialties, including anesthesiology. Other physicians simply do not perform the services provided by anesthesiologists; Hsiao terms anesthesiology an "insular" specialty. ASA does not accept, or even understand, the cross-specialty links for anesthesiology: there are only five links made for anesthesia services, loosely tied together by intra-service time:

Link	Specialty	Service Description
1.	an	Insertion of Swan-Ganz catheter
	gs	Insertion of Swan-Ganz catheter
2.	an	Anesthesia for dilation & curettage of uterus
	pe	Office evaluation of head trauma in pre-school child with episode of vomiting, established patient.

3.	an	Consultation for a transfusion reaction in patient with abrupt onset of fever and back pain
	ai	Medical conference by physician regarding medical management, with patient and/or family; counseling for avoidance, elimination, symptomatic treatment, and immunotherapy
4.	an	Anesthesia for repair of abdominal aortic aneurysm
	ob	Protracted labor requiring pitocin augmentation and electronic monitoring, primigravida, only time spent with patient
5.	an	Anesthesia for cesarean section
	im	Management of patient in acute pulmonary edema in emergency room who subsequently is admitted to hospital, established patient

Only one, insertion of Swan-Ganz catheter, is an actual link -- and anesthesiologists often cannot even get reimbursed for this procedure. The transfusion reaction consultation is not common in practice, and would not occur as an independent activity, but would be related to an ongoing procedure.

Perhaps a better example of the failure of cross-specialty alignment is link 5 for anesthesiology. The internist with the pulmonary edema patient is involved with a major interventional procedure and under a great deal of stress in an emergency situation. We do not see how this can be linked to anesthesia for a cesarean section, and would judge the internist to be undervalued in this "link" and the eventual RBRVs.

Use of Averages

There are also problems associated with using averages, with respect to time or procedure complexity, when constructing an RBRVS. Even under conditions of budget neutrality, the assumption is that on the average, gains and losses, given a large enough number of cases, should offset one another. It is unlikely that there will be case mix differences in kind and number of procedures within and between individual physician practices to allow the winners and losers to offset one another. Hsiao acknowledges this when he states: "Within a specialty, therefore, individual physicians might be differently affected by an RBRVS-based fee schedule, depending on the mix of services they perform."

RBRVS Conclusions

We must underscore that our comments on the Hsiao study and the PPRC recommendations by necessity reflect a high degree of

uncertainty because the anesthesiology simulations have not been completed. We can anticipate that the RBRVS will eventually generate a system of relative values from a small subset of procedures to all anesthesia procedures using the existing ASA RVG. While we are pleased with recognition of our RVG, the major problem with this approach is that it does not incorporate the existing large variation in time within procedures with comparable basic units. Hsiao assumes a constant relationship between time and other factors used to define the amount of physician work involved in a procedure. The appropriateness of the RBRVS for anesthesia services depends on how time and other factors not under the direct control of the anesthesiologist are incorporated into the system.

The existing ASA RVG represents a realistic approach to payment reform since it incorporates units representing the anesthesia complexity of a procedure, the duration of the procedure and patient severity of illness. It is a system which has credibility with payors and researchers, is termed valid by Hsiao and PPRC, and is recognized by HCFA. ASA believes all components of its RVG can be integrated successfully into the Commission RBRVS.

Other Recommendations of the PPRC

Beneficiary Choice and Balance Billing

The assignment rates for anesthesiologists have increased significantly over the past five years. ASA understands that information (based on an 8-state survey) presented to PPRC by its staff and consultants shows a 70 percent assignment rate for anesthesiologists; other physicians appear to be closer to 80 percent.

One reason for a lower assignment rate is that anesthesiologists receive markedly less "on the dollar" from Medicare than do other specialists. According to data from HCFA and PPRC, the Medicare prevailing charges for anesthesiologists are 40 to 50 percent less than the anesthesiologists' MAAC charges; the reduction rates -- that is, the difference between the prevailing and the MAAC -- for other specialties do not approach this disparity.

Anesthesiologists do not have access to the same financial information about the patient as does the referring physician. Unfortunately, the discussion of the patient's financial situation frequently comes after the bill has been sent and it becomes apparent that the patient is financially unable to pay. In such a situation, many anesthesiologists will then write-off the patient's bill, but because of the time at which the write-off occurs, the transaction does not appear in the system as an assigned claim.

It makes sense that patients are generally sicker, using more intensive services and accruing greater charges when anesthesia services become a factor. In fact, anesthesiologists' services do not become significant until the patient is in the 95th percentile of Medicare-approved charges per individual. The combination of intensity of service and Medicare reimbursement amounts lagging 40 to 50 percent below charges, account for anesthesia balance bills representing about ten percent of balance bills.

ASA has also indicated to the PPRC and the Congress that we would support an income-related assignment system. This would be an equitable method to assure those in financial need receive consideration, while those able to pay the already-discounted MAAC charge would do so.

The argument has been made that anesthesiologists should have special assignment rules because the patient generally does not select the anesthesiologist, i.e., the opportunity to shop for a participating physician is not available. ASA believes this is an extremely weak argument. Patients rarely select beyond their primary care physician; it is the primary care physician who refers patients on to their choice of surgical specialist, cardiologist, oncologist, etc. In many other situations, the choice is made by the hospital, clinic, managed care system, or by a specialist who is already once removed from the primary care physician.

ASA understands that the PPRC Report will indicate that the Commission considered, but rejected, a prohibition on balance billing for select physicians, including anesthesiologists. The PPRC apparently agrees that the definition of limited choice physicians is not clear cut. Further, PPRC would prefer to assess the impact of its recommendation concerning universal limits on balance billing that will be associated with the RBRVS and fee schedule. ASA supports the PPRC's decision not to recommend different treatment for certain specialists.

To target anesthesiologists as radically different -- as to assignment rates, balance bill liability or lack of patient choice -- appears without foundation.

In past years, this subcommittee has recognized that anesthesiologists are not in a position to influence volume. However, there is a related issue with which we have dealt: if we cannot control the number of anesthesiology services being provided, we can address the quality and performance of each service. In other words, we can seek to assure that anesthesiologists provide the services that are being reimbursed.

ASA was the first specialty to set national standards and has adopted four to date: Basic Standards for Preanesthesia

Care; Standards for Basic Intra-Operative Monitoring; Standards for Postanesthesia Care; and Standards for Conduction Anesthesia in Obstetrics. The most important role of standards is to improve patient safety, but they also can tell the patient and insurer that they have received what they paid for.

Regarding several of the other specific recommendations contained in the PPRC Report, ASA makes the following comments:

- Recommendation: Premiums for liability insurance should be integrated into the RVS through a separate practice cost factor. The medical liability crisis continues to be out of control. Anesthesiologists have gained some relief in premiums due to the standards set by ASA and other risk management initiatives. ASA supports the intent of PPRC's recommendation: 1) separate consideration of the liability factor will help show the unacceptable costs; and 2) there will be consideration of both geographic and practice differences.

- Recommendation: Fee schedule payments should vary geographically. ASA supports valid geographic cost of practice variations.

- Recommendation: A uniform policy on the delineation of carrier charge localities is needed. Carrier variations, both as to coverage decisions and payment rates, follow no clear pattern. Any improvement of the charge area boundaries would be a step toward uniformity in the program.

- Recommendation: A transitional stage should begin in 1990, with implementation of the full Medicare Fee Schedule planned for 1992. Although ASA is pleased that its RVG is being considered as an alternative to development of new values, the specialty of anesthesiology has not been fully considered by either Hsiao or PPRC. Without knowing the outcome, ASA cannot support a 1990 implementation of the RBRVS, and suggests 1991 as a more reasonable date. Considering the overwhelming changes the RBRVS will bring to all of medicine, we believe it is worth taking the time to do it correctly.

ASA further strongly recommends at least a three-year transition period to the fee schedule. The disruption to physicians and patients of a relatively abrupt transition would undermine the reforms and discourage the needed physician cooperation.

- Recommendation: A national expenditure target should be used to determine annual conversion factor updates under the fee schedule. ASA has two comments with regard to expenditure targets. First, within the context of the PPRC report, we must say that until the RVS conversion factors are known, it is difficult to assess the impact of expenditure targets. Further, the concept of seeking to exert peer pressure among 500,000 physicians to meet a national target is an unrealistic approach to controlling volume.

COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists appreciates the opportunity to comment on the 1989 recommendations of the Physician Payment Review Commission. The College represents more than 10,500 physicians who are board-certified in pathology. Our members provide patient care services in hospitals and independent laboratories.

Physician Payment Review Commission (PPRC) Recommendations

The College commends the Commission on its work and supports some of the proposals made by the Commission. Other recommendations are premature or unwise in our view. We strongly advise against adopting all of the PPRC recommendations. We submit the following specific comments on the 1989 recommendations of the Commission:

1. The College strongly advises against including pathology services in RBRVS implementation until the Hsiao restudy of our services is completed and the RBRVs have been subjected to the same rigorous review that has been applied to the RBRVS developed in the first phase of the study.

   The College of American Pathologists has communicated to the Physician Payment Review Commission on several occasions the need for a restudy of the resource-based relative values (RBRVs) of pathology services. The Commission's 1989 Report acknowledges that the Hsiao methodology must be improved and certain specialties must be restudied. The CAP has reached general agreement with William Hsiao, PhD, on the parameters of a restudy of pathology services that is scheduled to begin later this year and be completed in Fall of 1990.

   Use of the current RBRVS for pathology services is clearly inappropriate given the many problems with data collection and cross-linkage for pathology that we have identified. It is inequitable to implement a pathology RBRVS in advance of completion and review of the restudy.

   In addition, a report on a relative value scale fee schedule for pathology services is being prepared by the Secretary of the Department of Health and Human Services, as required by the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). This report could provide useful information on the relative values of pathology services.

2. We encourage the Subcommittee to reject the PPRC recommendation for a short (six month) RBRVS start-up period regardless of when authorizing legislation is enacted.

   We oppose implementation of a pathology RBRVS on April 1, 1990, and until the Hsiao restudy of pathology services is completed and has been subjected to rigorous review.

   The Commission recommends enactment of legislation this year to establish a Medicare fee schedule based on RBRVs with implementation six months after enactment and a two-year transition period.

   We believe there are ample examples in Medicare program history to support a conclusion that implementation of an RBRVS fee schedule will be characterized by disruption and confusion among physicians, Medicare carriers, and Medicare beneficiaries. Implementation of such a revolutionary change

without adequate preparation by the Health Care Financing Administration and carriers and with inadequate attention to communication to physicians and beneficiaries will only worsen the disruption that the change will produce.

We do not believe that a six-month period from authorizing legislation to implementation date is adequate for preparation and communication about the change. For example, if the Medicare Participation program is to continue then equity would require that physicians be given an opportunity to sign or rescind participation agreements based on knowledge of new fee schedule amounts. We do not believe that Medicare carriers would be able to establish the new payment methodology and provide physicians with the information necessary to a participation decision within six months of enactment of legislation.

3. We support and appreciate the decision of the Commission not to recommend mandatory assignment. We believe that Commission staff analysis of current balance billing characteristics demonstrates that balance billing amounts are not a problem for pathology services. Likewise mandatory assignment for pathology services would do little to reduce the out-of-pocket medical expenses that beneficiaries incur.

   It has been suggested that balance billing is inappropriate in the context of a Medicare fee schedule that seeks to rationalize payment among services and physicians. We believe that it is inappropriate to mandate assignment in the context of a new payment methodology, untested and as yet incomplete, that will likely require refinement and adjustment. We support the Commission plan to assess the impact of other fee schedule limitations before further addressing assignment policy.

4. The College opposes expenditure targets for physician services and outpatient laboratory tests. The Commission recommends a national expenditure target under Part B to be used to determine annual conversion factor updates under the physician fee schedule and for outpatient laboratory tests provided in a physician's office or outside laboratory. The target would reflect, in part, a decision concerning the appropriate rate of increase in volume of services per enrollee that would reflect tradeoffs between beneficiary needs, technological advances, and affordability.

   The College believes that physicians must share the responsibilities of balancing escalating costs, responding to questions of utilization, and assuring access to needed health care services. Practice guidelines for physician and laboratory testing services, appropriately developed and applied, hold promise for ensuring that needed care is provided and unnecessary services curtailed. The Commission also recommends other policies intended to reimburse physicians and beneficiaries appropriately for needed services, such as realignment of relative values of payment levels, new definitions of some service codes and service groupings, and development of practice cost and geographic variation factors.

   To impose upon this network of new payment methodologies a rationing mechanism such as expenditure targets is a radical departure from the Medicare program commitment to provide beneficiaries with (covered) medical-

ly reasonable and necessary services. When implemented in the context of Medicare policy intended to identify and pay for needed services only, an expenditure target would implicitly sanction withholding of payment for services that are needed. The obvious product of an expenditure target would be an incentive to ration needed services.

We encourage the Subcommittee not to adopt the PPRC recommendation for use of expenditure targets.

5. The College supports the development of clinically relevant practice guidelines that respond to questions of utilization of laboratory tests. We believe that physicians knowledgeable in applications and limitations of laboratory testing are the appropriate source of such guidelines. Federal funding for private sector physician-development of practice guidelines could produce clinically sound guidance that physicians can integrate into their practices.

   Toward that goal, the College sponsored a Consensus Conference on Appropriate Laboratory Testing Guidelines in March 1989. Representatives of medical specialties, the Blue Cross/Blue Shield Association, government agencies, industry and consumers participated in what we believe was a productive first step in development of appropriate laboratory testing parameters.

6. We support the Commission statement that a national fee schedule requires that codes for physician services be interpreted uniformly by all physicians and carriers. We believe that physicians who provide the services described by the codes should determine how services are coded and be involved in any effort to define coding policy. RBRVs for pathology services should not be implemented until ambiguities in coding interpretation and use of surgical pathology codes have been resolved.

Fiscal Year 1990 Freeze Proposals

The CAP also is concerned about certain inequitable 1990 budget proposals. The College opposes elimination of the MEI update for nonprimary care services.

The Administration proposes that nonprimary care services receive no prevailing charge update in 1990. Nonprimary care services are defined as services other than physician visits provided in an office, nursing home, home, or emergency department setting.

The Medicare Economic Index is an inflation index used to limit updates in prevailing charges to increases in overhead and general wage levels. Nonprimary care services are affected by inflation in overhead and other costs just as are primary care services. There is no credible evidence that pathology physician services are overpriced. We believe it is inequitable to forego the scheduled MEI update for pathology services.

The College would also oppose any proposal to freeze clinical diagnostic laboratory services in 1990. Payment for these services has been the subject of numerous reductions and limitations in recent years. In 1984 Congress radically

changed the payment methodology for Medicare clinical diagnostic laboratory services. In every budget reconciliation act since 1984 the Medicare fee schedule for these services has been subjected to additional restrictions, reductions, rebasing, or ceilings. Further restrictions could seriously compromise the quality of clinical diagnostic laboratory services.

Conclusion

The College of American Pathologists urges caution in early implementation of a RBRVS. In particular, pathology services should not be included in an RBRVS until the Hsiao restudy of pathology is completed and subjected to the same rigorous review that has been applied to other parts of his work.

We oppose the use of expenditure targets for Part B physician services and outpatient laboratory tests. Practice guidelines, appropriately developed and applied, offer greater promise for ensuring that the Medicare program pays only for needed pathology services and laboratory tests.

Thank you for the opportunity to comment on PPRC 1989 recommendations and Administration budget proposals for 1990.

STATEMENT OF MARTHA McSTEEN
PRESIDENT

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. The National Committee represents over five million members and supporters, most of whom are senior citizens. Physician payment reform is not only a pocketbook issue for the Medicare program and doctors, but it is also a pocketbook issue for senior citizens. They now spend 18 percent of income for out-of-pocket health care costs.

While the Harvard researchers and the Physician Payment Review Commission have done valuable work, it is up to Congress to see that these recommendations translate into more affordable and accessible health care for older Americans.

The National Committee has outlined beneficiary criteria for physician payment reform which include financial protection, quality care, and information and assistance (see attached). We would hope that physician payment reform would provide Congress the opportunity to address all these issues, but at a minimum it should guarantee beneficiaries financial protection from doctor charges above what Medicare allows and from Part B premium increases.

As we said in our statement last year, an overwhelming 72 percent of respondents to a National Committee member survey agreed that the federal government should regulate doctor and hospital fees. Two-thirds of the membership ranked, as one of their top two Medicare priorities, that doctors be required to accept assignment. Controlling premium increases was also a high priority.

We are disappointed that the Physician Payment Review Commission did not recommend limiting charges to what Medicare allows. Once doctor fees have been reformed, there can be no further excuse for permitting doctor fees above what Medicare allows. If Congress at least sets some limit on doctor charges above what Medicare allows, as the Commission recommends,

we hope Congress would use that as a starting point for phasing in a complete prohibition on doctor fees above what Medicare allows.

"'Excess' physicians' fees today represent one of the biggest gaps in Medicare coverage," according to the June, 1989, issue of Consumer Reports. The new Medicare Catastrophic Coverage Act provides no limits on these fees and most private medigap policies do not provide coverage for this. Not only do excess fees cost beneficiaries approximately $3 billion a year, seriously ill patients face the largest bills and have the least choice of doctors.

While considerably less than the last year's Part B premium increase of 38.5 percent, this year's premium increase of 12.5 percent (before the increase for catastrophic care) was more than triple the cost-of-living adjustment (COLA) for Social Security benefits. If the premium for catastrophic care is included, the premium increase is 28.6 percent. In other words, the premium has increased almost thirty percent in each of the last two years.

Beneficiaries have some reason to hope that next year's basic premium increase (excluding catastrophic) will be no more than four percent because current law would limit the premium increase to no more than the COLA. Unfortunately, the Administration has proposed increasing Part B premiums to cover 25 percent of program costs which would cost beneficiaries $7.7 billion dollars over five years, or approximately $518 per beneficiary.

Congress has an opportunity to reform Medicare payments for doctors in a way that will assure that beneficiaries are financially protected, that doctors are paid equitably and that patients are assured access to high-quality medical care.

Thank you.

Beneficiary Criteria for Physician Payment Reform

FINANCIAL PROTECTION

Eliminate "balance billing." Without a limit on doctor charges above what Medicare allows, the imposition of any fee schedule will do little more than serve as an open invitation to doctors to "balance bill" beneficiaries to compensate themselves for lost income. This is a particular danger with regard to specialty surgeons; their record on accepting assignment has been the worst, and now, under any conceivable fee schedule imposed by Congress, they stand to lose the most.

Limit Part B premium increases. Increases in Part B premiums should be tied to increases in the Social Security cost-of-living adjustment (COLA), as provided under current law for 1990 and future years. Medicare beneficiaries pay $382.80 per year in part B premiums alone. This is the out-of-pocket cost for a healthy Senior who does not visit a doctor even once for an entire year. The Administration proposes to increase Part B premiums to cover 25 percent of program costs. This could cost beneficiaries up to $10.5 billion over five years.

QUALITY CARE

Assure that care is necessary and appropriate. Since 1972, Medicare has relied on utilization review to identify unnecessary or inappropriate care. It has not worked well, and the Physician Payment Review Commission concluded that, as currently practiced by Medicare, it can't---"without risk of reducing quality of care." The commission favors a clearer focus, more research and less secrecy.

Assure that care meets quality standards. The only leverage that Medicare has is to deny payment to doctors who provide substandard medical care. In 1986 Congress ordered Medicare to actually start doing this. Implementing regulations only recently have been proposed. They would provide for the denial of payment only when medical care results in "actual, significant, adverse effect."

The peer review organizations (PROs) whose job is to watchdog doctors have failed to do so, according to the Physician Payment Review Commission. Its 1988 report cited a HCFA finding that half the PROs "failed" their contractor performance evaluations because they had done nothing about the instances of inept or harmful medical care they had discovered.

INFORMATION AND ASSISTANCE

Make program rules clear and understandable. Abolish needlessly complex rules (e.g., the MAAC) that are incomprehensible and annoying to patients and doctors alike. Agency and carrier communications to beneficiaries should be clear and understandable, timely and polite.

Assist beneficiaries in filing claims and appeals. Restore Medicare's practice of offering help to beneficiaries in local Social Security offices. Encourage Medicare carriers to undertake efforts in "beneficiary outreach," as suggested by the Physician Payment Review Commission.

Publicize clinical criteria and physician performance data. Throughout its 1988 report to Congress, the Physician Payment Review Commission called upon beneficiaries to help reduce the volume and intensity of medical services and to help eliminate services of marginal value. The Commission acknowledged the obvious fact that doctors are the key decision-makers. Neverthless, it wants beneficiaries, their families and organizations to help control doctors' prices and doctors' behavior. This is not remotely possible unless beneficiaries and advocates have the data and information on which to base informed decisions.